



The MODERN HOSPITAL

Volume 43

DECEMBER, 1934

No. 6



EDELWEISS

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THE recent news of a four-foot snowfall in Quebec may have shocked some of us into a realization that Christmas is almost here. The special Christmas article this month will be found in the dietetic department, because this department more than others assumes responsibility for making the Christmas season happy for those who must be in a hospital. The article describes how Christmas is observed in several small hospitals (page 94).

SMALL hospitals are coming in for special attention this month. On page 75 Doctor Pollak has set forth an accounting system that has been evolved by a small institution and found satisfactory.

ONE of the features of The MODERN HOSPITAL that has been most frequently praised by readers is the set of menus published each month. First the dinner menus and now menus for breakfast and supper. In order to make these of even greater service and to be sure that they are in the hands of the dietitian when needed the schedule is to be moved up a month. The January issue, therefore, will contain menus for both January and February and thereafter the menus will be given one month in advance.

PRACTICAL economy in the hospital is always a timely subject. An excellent brief article on this subject with many specific suggestions will be presented next month. It is by W. Mezger, assistant superintendent, Michael Reese Hospital, Chicago.

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CONTENTS

WHAT do you know about blankets? Of course they keep you warm and some wear out faster than others. But would you like to know how you can tell the long-wearing ones before you buy them? Next month the purchasing agent of a New England hospital will tell the story.

THAT final report which the Committee on the Grading of Nursing Schools recently published may one day be considered a bench mark in American nursing. What do hospital superintendents think about it? Next month a symposium on this subject will reveal what they think.

THE material that has been coming in on the subject of "Distinguished Service in the Hospital" indicates that that article in the September issue struck a responsive chord among hospital people and others interested in the health of the nation. This month short statements by Dr. Lucius R. Wilson and John N. Hatfield are published. Next month additional material will be presented. Further comments from readers will be welcomed.

THOSE who have enjoyed the salads prepared by Arnold Shircliffe will be delighted to know that he has created several new ones for special occasions. The Christmas salad is given in this issue and special ones are coming for St. Valentine's Day and Mother's Day. These original salads have all been created by Mr. Shircliffe especially for our readers.

NE X T month marks the opening of a new year. With it comes the necessity of writing a report on the year just passed. But there are annual reports and annual reports. Many of them are dry-as-dust. They repel the reader. They discourage him. The editor of a hospital magazine must read annual reports. It is a pleasure when he finds one that is especially attractive in for-

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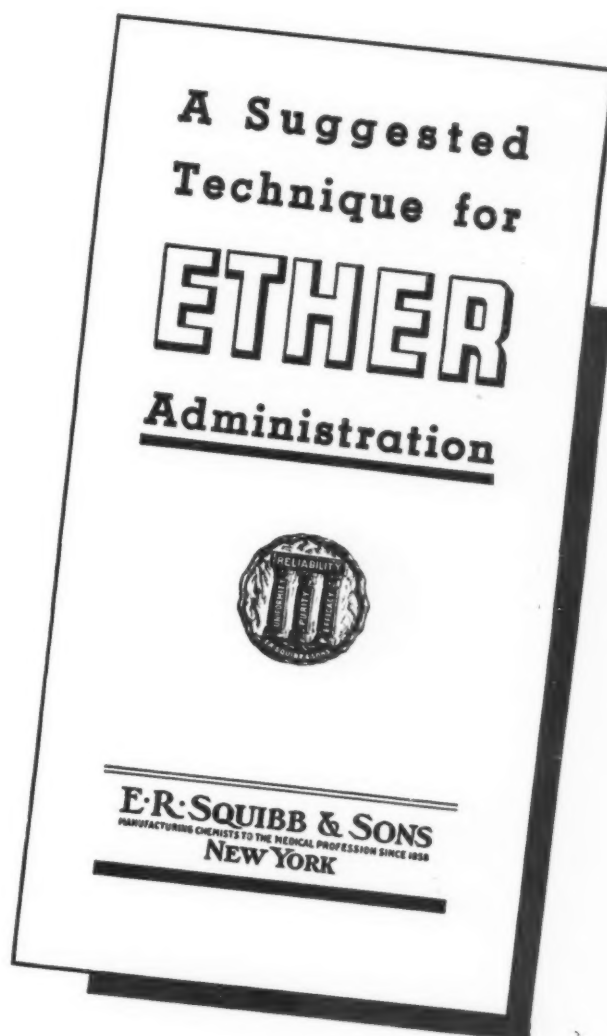
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Now IN BOOKLET FORM...

FOR the past ten months, in a series of advertisements, E. R. Squibb & Sons have suggested points of technique regarding the administration of ether. The response to these advertisements has indicated a nationwide interest.

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mat, is written like a best seller and gives all the important information without a load of nonessentials. Such an annual report arrived recently. Its author will give in January his plan for creating a worth while annual report that will be read.

STAMP collectors will be interested in knowing that a special cachet is being sponsored by Robert Packer Hospital, Sayre, Pa., to commemorate the opening of the new hospital on December 6. Any hospital people wishing a first day cover may have one on sending a request to the hospital.

FLASHES FROM THIS ISSUE:

"The establishment of new hospitals by new groups entering the hospital field in the last twenty years has resulted in overcrowding the field and in under use of the beds, with embarrassment to all managers." *Page 44.*

"It is my belief that any hospital averaging fifty patients a day can save money by investing in a small multi-graph press. By this means records can be turned out at less than one dollar per thousand copies." *Page 49.*

"The wise dietitian . . . will begin her Christmas preparations a month or so ahead of time." *Page 96.*

"In respect to both trained staff and competent continuous direction the majority of schools of nursing have a long way to go before they reach the standards now commonly in force in other types of professional schools." *Page 69.*

"The idea of better living accommodations for domestic workers is based on the sound assumption that satisfied help makes satisfied patients." *Page 40.*

"The success of a hospital training program is not due to the efforts of any one man. It is dependent upon the concentrated efforts of the entire staff, all of whom must untiringly give of their time and interest in a coordinated course of instruction." *Page 64.*

"With the exception of emergencies, nearly all work can be definitely scheduled and the time set the evening before." *Page 49.*

THE MODERN HOSPITAL

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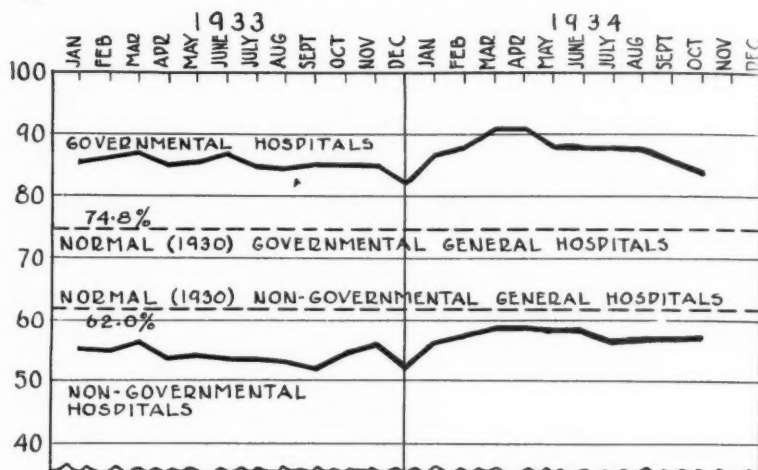
The Hospital Barometer

Occupancy in nongovernmental general hospitals continued in October at practically the same level as in the preceding four months. It remained nearly three points higher than during the corresponding month of last year. Governmental general hospitals on the other hand continued to find a slackening in the demands upon them. In October the occupancy of governmental hospitals dropped below last year's figures for the first time in many months.

Seventeen new hospital building projects were reported between October 22 and November 19. Of these one was a nurses' home, three were new hospitals and thirteen were additions to existing hospitals. Costs were reported for only eleven of the projects. Total costs reported were \$2,464,300.

Business improved a little more than was seasonable in October, according to the National Industrial Conference Board. Declines in production were more than balanced by gains in building and engineering construction. General distribution and retail trade advanced in October by seasonal amounts over September levels. The most noticeable change in October was the upturn in residential construction. Automobile output fell off more than seasonably but steel and iron production made more than seasonal gains. Electric power output advanced seasonably and bituminous coal production showed continued improvement. The textile industry was stimulated following the low level during the September strikes.

The general price index of the *New York Journal of Commerce* declined the last two weeks in October, advanced during early November and then fell back to 75.8. (It was



79.8 on September 1.) Grain prices advanced sharply, the index going from 83.9 on October 27 to 88.9 on November 24 (1927-29=100). General food prices advanced from 65.8 to 66.2 during the same period. Textiles, fuel and building materials remained practically unchanged. A slight decline in the *Oil, Paint and Drug Reporter's* price index for drugs and fine chemicals was recorded during the period.

The first decline in the cost of living for wage-earners since April was recorded by the National Industrial Conference Board in October and it was only 0.1 per cent. Living costs in October were 3.7 per cent higher than in October, 1933, but 19.9 per cent lower than in October, 1929. Retail food prices, according to the board's report, dropped 1 per cent, contrary to the usual seasonal trend. Rents increased 0.6 per cent, clothing dropped 0.1 per cent and retail coal advanced 0.2 per cent.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals ¹		1933			1934									
	Hospitals	Beds ²	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.
Nongovernmental															
New York City ³	68	15,194	65.0	68.0	65.0	69.0	70.0	73.0	75.0	75.0	75.0*	66.0	62.0	61.0	61.0*
New Jersey.....	58	9,772	58.0	61.0	57.0	58.0	62.0	63.0	63.0	63.0	61.0	61.0	59.0	58.0	58.0*
Washington, D. C.....	9	1,763	58.9	59.3	57.7	61.7	65.0	67.2	65.8	62.8	62.8	58.4	59.3	60.7	65.4
N. & S. Carolina.....	97	5,717	52.6	54.2	51.3	54.0	57.3	59.2	59.4	59.6	62.1	62.6	62.3	60.9	61.1
New Orleans.....	7	1,178	43.3	44.9	43.1	42.4	43.4	46.5	42.1	43.2	48.4	43.3	52.1	49.5	49.5
San Francisco ⁴	15	2,825	56.3	58.1	53.9	59.5	63.0	61.9	61.6	60.3	58.1	56.8	56.9	60.8	64.2
St. Paul.....	5	792	44.7	48.8	46.0	51.8	53.8	49.4	50.7	47.3	49.1	44.9	45.7	43.4	39.1
Chicago.....	23	6,013	50.7	51.5	49.1	53.1	53.5	53.3	55.4	56.5	57.7	57.3	59.3	55.6	56.9
Cleveland.....	13	2,956	60.0	61.0	55.0	57.0	58.0	58.0	61.8	59.9	61.3	60.0	58.4	56.7	58.7
Total⁵.....	295	46,210	54.4	56.3	52.6	56.3	58.4	59.1	59.4	58.6	59.5*	56.8	57.2	56.3	57.1*
Governmental															
New York City.....	16	11,615	103.3	106.6	104.5	100.7	100.0	105.0	103.7	101.9	93.7	91.3	89.5	88.3	89.4
New Jersey.....	6	2,122	86.0	88.0	82.0	89.0	94.0	93.0	91.0	90.0	86.0	85.0	80.0	80.0	80.0*
Washington, D. C.....	2	1,076	83.8	87.6	87.8	87.1	88.3	83.2	84.3	84.7	84.7	79.0	80.2	81.7	78.1
N. & S. Carolina.....	13	1,136	58.2	56.6	50.6	58.6	65.8	66.4	66.8	64.5	69.4	70.6	66.9	64.0	65.3
New Orleans.....	2	2,227	111.1	105.3	96.8	106.6	112.5	129.5	136.4	127.1	137.9	148.7	152.4	148.0	129.3
San Francisco.....	3	2,315				77.4	79.2	76.7	80.7	77.7	76.4	77.9	74.4	72.7	
St. Paul.....	1	1,050	74.4	71.1	72.4	79.8	78.5	76.9	76.3	76.1	73.2	69.0	68.0	67.3	66.8
Chicago.....	1	3,101	80.9	81.3	80.6	92.8	94.3	93.2	94.6	91.1	87.5	84.8	83.7	83.1	84.8
Total⁶.....	44	24,642	85.4	85.2	82.1	87.8	88.8	90.8	91.2	89.5	88.8	88.1	87.3	85.9	83.3

¹Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. ²Including bassinets, in most instances. ³Includes only general hospitals. ⁴Includes only 9 hospitals with bed capacity of 1845 through November, 1933. ⁵The occupancy totals are unweighted averages. These averages are used in the chart above. ⁶Preliminary report

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 43

December, 1934

NUMBER 6

"Signs of the Times" in Evanston

By RAYMOND P. SLOAN

Associate Editor, The MODERN HOSPITAL

A STORY unfolds itself before the eyes of the visitor who stands on the roof of Evanston Hospital, Evanston, Ill., a story of steady growth. It starts before this town emerged from shy countryhood into pretentious suburban proportions. It starts with a small medical unit which quickly left its adolescent period behind and stands today among the foremost ranks of modern American hospitals.

It is not necessary to go back more than twenty years to visualize the changes that have taken place. Twelve or fifteen miles from the heart of Chicago, Evanston was then country. Today its population numbers approximately 60,000. In those early days beyond the eight acres on which the hospital stands were meadows with elaborate country homes scattered here and there. A typical suburban community now flanks the hospital grounds on all sides, with the elevated to Chicago but a stone's throw from its rear entrance.

Just one feature of the landscape has remained constant through the years. Lake Michigan now, as always, portrays its varying moods from dazzling brilliance to sullen anger.

Originally, the main hospital building itself assumed more the atmosphere of a country home than an institution. Then, new needs had to be faced. Modern trends in medical science inflicted additional responsibilities upon hospitalization. The hospital started as a part of the community and has grown up with it.

From our point of vantage, this gradual development is plainly visible. In back stands a brick building facing a rear street, evidently an old timer in the group. This assumption proves correct. It was, and still remains, the contagious unit, but instead of every floor being occupied as was true at one time, patients are now confined to one floor. Better health conditions and immunization against disease have taken the burden from this department and

Once a small suburban hospital, Evanston Hospital, Evanston, Ill., today assumes city proportions, its outpatient department alone having administered to 20,000 people during the past year and its bed occupancy having grown to 250. How has it kept pace with the demands for modern hospitalization? Our Little Journey having led us to its front door, let us walk in and find out



The architectural details of the General Building, erected in 1919, are shown in this photograph of the upper stories and roof.

placed it elsewhere—on the out-patient department, for example, demands on which have grown steadily. Last year patients made over 20,000 visits.

At the rear and a bit to the left is a modern building constructed in three wings, obviously a recent addition to the group. It is known as Patten Memorial Hall, the new nurses' home, which was made necessary because of the establishment of higher standards of nursing education and the need for better housing accommodations.

Alongside it stands another substantial brick building, Hendrey House, entrance to which is from the rear street as well as from the hospital itself. This is a club house for male and female domestic help named in honor of the chief engineer who has been with the institution since 1901.

There is no question that the long low one-story wooden building protected on three sides by taller structures belongs to an earlier group. Yet despite its old time air, it plays an important part in the business of the day. It is the shop, and in every department of the hospital will be found evidences of its handicraft.

Lake Michigan portrays its varying moods from dazzling brilliance to sullen anger, when seen from the roof garden atop the General Building.

Demands for modern conveniences and attractive dress in private rooms have, of course, been heeded, with additions and units to meet the most fastidious tastes. Even the older buildings have been modernized in line with new conditions. A bay window on the ground floor has been cut down to make a doorway opening into a sunshiny, cheerful suite of rooms devoted to out-patient department activities. This department registered over 20,000 visits during the past year. A wing on the ground floor of the original

building, which formerly contained the offices and later housed the interns, has been transformed into a library which is in charge of a full-time professional librarian. Progress—new ideas, everywhere, outside as well as within!

Fortunately, a well informed guide accompanies us as we leave the roof and step into the occupational therapy room—none other in fact than Ada Belle McCleery, superintendent. During the twenty years Miss McCleery has been identified with Evanston Hospital, she has had to face and solve problems connected with practically every





The flower garden and grape vine at the north end of the grounds help maintain the country atmosphere.

department. Certain of these problems are peculiar to her own hospital; others represent much the same questions as are confronting other hospital executives throughout the country. Some center around mere details; others involve major routine. In each instance the solution she has worked out is interesting, and suggestive.

Even in passing through the occupational therapy room to the elevator, it becomes necessary to make notes. First, the room has atmosphere. It creates an impression of activity. Bright yarns and raffias point to real achievement. A row of bottles on one table in process of decoration reveals an interesting idea. Bottles in which food or other products are delivered to the hospital and which are suitable as flower holders are sent to the occupational therapy room where they are decorated. Thus, completely rejuvenated and glorified, they make a second entrance into hospital life.

The next stop in the elevator is the basement where in the kitchen and dietary department all manner of unusual ideas are encountered. Who, for example, has ever heard of glorifying the dust cloth? Yet that is precisely what is being done at Evanston where it assumes a soft shade of blue through the simple process of tinting or dyeing

before being put into circulation. It gives the humble rag a new importance. Furthermore, there is no chance for towels, napkins, and more important linens, being used as substitutes. A dust cloth is a dust cloth, and that's that.

What to do with soiled towels and cloths in the kitchen is always a question. Too often a hamper or receptacle, if provided at all, is not accessible. A practical solution is a good-sized bin with doors beneath and a hole on top large enough to receive cloths. It was built in the hospital workshop from which a thousand and one clever ideas emanate and is conveniently placed in an auxiliary room adjoining the kitchen.

How much time can be wasted and how many needless steps taken in assembling necessary ingredients for baking! Here it is made easy, where everything with the exception of white bread is baked in the hospital's own bakeshop. On one side of the room is a long worktable above which and below are banks of different sized bins made of nontarnishable metal. Smaller containers for spices and materials used in lesser quantities are above. Below are the bigger bins for meal, corn, flour. Everything for baking is within reach. Alongside this bench is a large mixing drum.

It was conceded some time ago that as bread crumbs are used so extensively in the preparation of food, proper facilities should be provided for drying the bread. A special warming oven holds all bread designated for that purpose. The crumbs are removed from this as they are needed.

The subject of bread leads to the investigation of a pile of metal containers just about the size of a loaf piled up in one corner. They are bread boxes in which sliced bread is sent up to the various floors. Any slices that are not served are returned in the same manner. Coffee, too, is distributed in large vacuum containers filled direct from the urns in the kitchen.

An ice box door opens to reveal row after row of small round cups in which are individual portions of ice cream. The ice cream is packed in these containers, eliminating any chance of salt or ice marring the flavor. In private room service, the cream is removed from the cup and put on a plate. In catering to the wards, however, the cream is served in the cup which is attractively decorated in a delicate blue.

Down With the Caste System

So much for these interesting details. Before progressing farther, we pause a minute to consider the weighty problem of democracy — hospital democracy. It is to be desired above all else, Miss McCleery believes. She took the first step in this direction some time ago in eliminating separate dining rooms for different classes of help and establishing one central cafeteria. After all, the scrub-woman and the prima donna rub elbows amicably enough as they pick up their trays in the public cafeteria and promenade by the steam tables. Why then, should not the hospital cafeteria serve all ranks with the same democratic spirit?

When the plan was first inaugurated, some limitations were made. It soon proved so popular, however, that all barriers were removed. Today everybody in the hospital, with the exception of those in the school of nursing who have their own dining room in Patten Memorial Hall, eats in the cafeteria. And they like it.

There is every reason why they should. The room, which is located on the first floor of Hendrey House, the club house for domestic help, is easily accessible to the street and to the hospital. It is airy, cheerful and the food is arranged appetizingly on counters.

Employees know that excellent mulligatawny soup at five cents is a good "buy," that roast lamb or corn beef hash at fifteen cents a portion is hard to beat, with a generous portion of mashed potato for five cents. Examination of the array of desserts makes a quick decision difficult. Pumpkin pie

at seven cents, for example, is worth considering, but then there are mysterious looking puddings for the same price and ice cream at either five or ten cents, according to the condition of the pocket-book and the size of the appetite. If there is any inclination to make it a full course meal, a tomato salad can be added for ten cents.

It is not unusual for the cafeteria to feed 250 people at noon. This includes all hospital workers, as well as their guests. Everyone likes the independence which the plan affords. It has eliminated complaints. Private nurses, who are paid direct by the patient and employees of the hospital alike, are privileged to eat elsewhere if they choose. Invariably they select the hospital cafeteria.

Life Runs Smoothly in Employees' "Club House"

While in Hendrey House, it is well worth the time to look around a bit. The democratic atmosphere which characterizes the cafeteria is manifest throughout the whole building.

The idea of better living accommodations for domestic workers is based on the sound assumption that satisfied help makes satisfied patients. A private room is provided for each employee. Steel doors on every corridor separate the men's rooms from the women's. They are locked, and the key kept in the superintendent's office. Two other doorways are provided to assure flexibility. Thus, if the number of men exceeds the number of women, the steel doors can be removed and placed elsewhere to increase or decrease accommodations for either sex, as the necessity may arise.

There is an elevator at each end of the building. When a new employee joins the staff, he deposits \$1 for the key, sufficient to cover the cost of providing a new one should he lose it or carry it away with him. The women make their own beds, but the men's beds are made for them. Once a week each room is cleaned thoroughly.

The first floor affords all the conveniences of a club house. There is a common entrance for both sexes from the street. Reception and recreation rooms are provided for men and women. All doors have been removed but the fact that the cafeteria is on the same floor, with members of the staff going back and forth ensures good discipline, as well as thorough maintenance. The girls are permitted to receive men visitors in their reception room, but are not allowed access to the men's recreation room. No serious infringement of these rules has been recorded. Hendrey House houses a group of industrious self-respecting citizens residing peacefully under the hospital's democratic rule.

Miracles in rejuvenation take place daily in the shop building. Old furniture for new may sound like a slogan, but here it becomes an established

fact. Every chair that comes in to be painted is examined for other deficiencies. It goes out ready for new responsibilities, wholly transformed by a coat of fresh paint.

The next stop is Patten Memorial Hall, the most recent addition to the hospital group. It is more than a nurses' home, for nursing education at Evanston is based on the premise that medical education and nursing education must go hand in

in the straight, three-year nursing course. The first leads to a college degree in addition to the R.N., the second merely to the R.N.

Classrooms and laboratories of the most modern type are provided, including a particularly well equipped dietetic laboratory. There is a spacious auditorium for various school exercises as well as for dances and other social events. The dining room is tastefully decorated, and has tables that



Above is the large, attractively decorated lounge on the first floor of the nurses' home, Patten Memorial Hall.



At the left are two of the four little sitting rooms off the corridor at the rear of the main entrance lobby.

hand. Therefore, in designing this building, now occupied by approximately 125 students, every effort was made to establish a complete unit for the modern scientific training of young women desirous of making nursing a profession, at the same time supplying them with a cultural background during their years of study.

The hospital has a college affiliation with Northwestern University. Girls desirous of entering the hospital matriculate at the university. Two types of students are enrolled, those wishing to take a five-year course, two spent at the university and three at the hospital, and those interested merely

seat four. Some of the food is prepared in the pantry and kitchen but the principal dishes are sent from the main hospital kitchen.

In addition to the large lounge on the first floor, four attractive little sitting rooms have been devised at the rear of the main entrance, for family conferences and strictly private conversations. Each has its own distinct decorative treatment and contains a love seat or small settee, two or three chairs, a table and harmonious lamps.

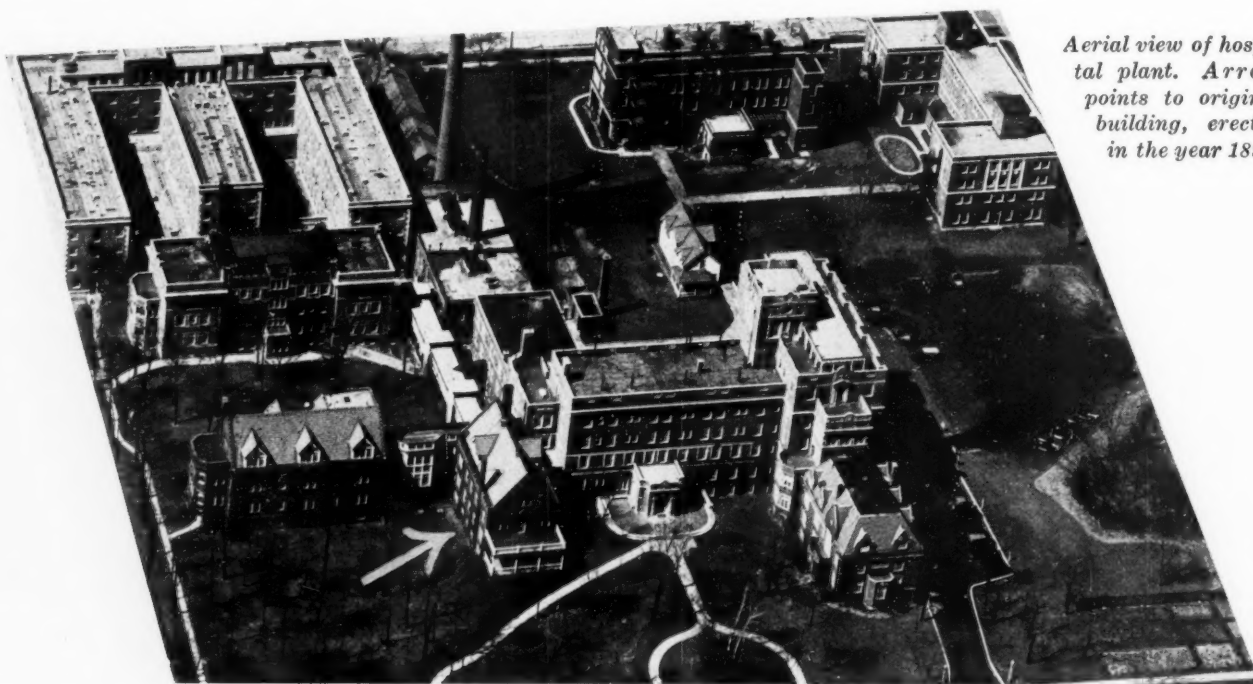
Right here, it might be well to jot down an idea for nurses' homes. Why not start a collection of pictures of graduates from the first year's class

up to the present. One girl comprised Evanston's first graduating class. There she is with her billowy skirts, leg-o-mutton sleeves and "Gay Nineties" air. The collection is mounted on a bulletin board, placed on the first floor corridor, and is entertaining to say the least.

In addition to housing its employees comfortably, the hospital offers them insurance through a group plan. This takes the form of a death bene-

Hospital charges are fixed on a flat rate basis. These prices include everything except telephone calls. There are no extras for the use of the operating room, x-ray or anesthetic. Whether the patient stays one day or ten is merely a matter of multiplication.

Here is a suggestion for those hospital heads who encounter difficulty in keeping patients happy the first thing in the morning while they are wait-



Aerial view of hospital plant. Arrow points to original building, erected in the year 1898.

fit policy. After six months of employment those engaged in mechanical labor are eligible to carry a policy amounting to \$1,000. Those engaged in an executive capacity, such as supervisors and department heads, are eligible to assume a \$2,000 policy. The insured pays sixty cents a month per thousand, and the hospital pays the balance. No medical examination is required. In five years four deaths have taken place. It costs the hospital about \$1,000 and has proved money well invested.

The matter of vacations always presents a problem to the hospital administrator. Here is how it is handled at Evanston. A full year's work is necessary before the employee is entitled to a vacation. Then he gets his time off whether or not he returns to his post. Those engaged in supervisory activities or others whose duties bring them in direct touch with the patient, such as the nursing staff, get thirty days' vacation. Domestic help and those doing mechanical work about the institution are on a fourteen-day basis. At the end of each five years, the fourteen-day class gets an additional week. The thirty-day group gets an extra week at the end of five years, two weeks after ten years, three weeks after fifteen.

ing to be made comfortable for the day. Supply them with a morning paper with the compliments of the institution. The small expense involved is more than compensated by the fact that the patient is kept entertained and is less apt to grow impatient at any delays.

In such ways from modest beginnings a small suburban hospital has assumed the proportions of a big city medical center. Sound organization built around a democratic form of government with resultant better service to the patient has been the keynote. To this add able leadership and complete accord between the executive management and the trustees, and the story is complete.

The already bulging notebook should carry one more item, however. To guide public relations activities and to help in preparing printed matter which will present the hospital's story favorably to the public, nothing is quite as efficacious as the services of a professional advertising man. If he can be included on the board of directors, so much the better. Evanston Hospital speaks on this with the voice of experience, which without doubt is another reason for its progress step by step with the community it serves.

Community Chests and Hospitals

Contributions to hospitals from community chests are declining. Private hospitals in the future will be less likely to make up budget deficits from voluntary contributions. Government hospitals will probably provide charitable service, and voluntary hospitals will have to exist on earnings—either from the patients' purses or from large scale group insurance

By FRANK D. LOOMIS

Secretary, The Chicago Community Trust

THE community chest is an organized method of securing and distributing contributions for the current financial needs of participating charitable agencies. It is a new method, devised to help to meet the growing needs of a growing number of charitable and social agencies, both old and new. It endeavors to bring about better order, system and equity in the solicitation and distribution of funds, in a field where needs are great and funds are limited. There is in the community chest both an element of cooperation and an element of control.

The hospital is an old institution, almost as old as charity itself. For centuries it was an infirmary, to which came the halt, the sick and the blind, the aged and the forsaken, to receive such care as medieval charity and medicine could provide, and to die.

Modern science has changed the hospital. It is now a place of recovery, to which people go in expectation of renewed health. It renders a service which is needed at times by the rich and the well-to-do, as by the poor. It renders a service that people will pay for when they have the money. For superior service they may pay lavishly. So the

modern nongovernmental hospital has become a business institution, operating to attract the patronage of people who can pay for service and pay at a rate that represents a profit. This is true even though the hospital is still a charitable hospital. It uses the profits from pay patients not for personal gain but to further improve its service, thus to attract more patients; and also to provide more or less free service to indigent patients or those who can pay only a little.

Modern Hospital Depends on Earnings

The ancient hospital was supported almost wholly by charitable gifts. The modern hospital is supported largely by earnings. The present proportion of income from the latter source, even among hospitals which have their roots deep in the heritage of charity, is quite startling. Four studies on this subject, summarized by Doctors Davis and Rorem in their recent book "The Crisis in Hospital Finance," revealed that in our leading charitable hospitals in our great cities, North and South, the proportion of income earned from patients averaged above 60 per cent. The hospitals in the United Hospital Fund of New York City averaged 66.8 per cent. These were all bona fide charitable hospitals.

The next highest source of income for the private hospitals in most of the cities studied was from tax funds, that proportion being in excess of 25 per cent. Endowments furnished above 3 per cent of the income and contributions less than 10 per cent. In cities where tax funds were not extensively used, the percentage from contributions ran higher, but not above 30 per cent.

Summaries of financial statements of 28 leading charitable hospitals in Chicago for the five years 1928 to 1932, inclusive, prepared by The Chicago Community Trust, showed sources of income as follows: earnings, 80 per cent; contributions, 10 per cent; endowment, 8 per cent; miscellaneous, 2 per cent. Total expenses for the five years exceeded total income by \$1,163,002, or 2 per cent. Up to 1932 these Chicago hospitals had no subsidies whatever from public funds.

These factors of income from earnings and from tax payments have an important bearing on the relation of hospitals to community chests and other methods of obtaining contributions. Doctor Davis states that "the proportion of earned income

in the hospitals of the United Hospital Fund of New York has doubled in the last twenty years," in spite of the vigorous and successful efforts of the fund to maintain contributions.

Another important phase of hospital finance has to do with its large need for capital funds. There is almost constant demand for scientific equipment, which is expensive and in which the rate of obsolescence is high. New buildings and new equipment are called for. Hospitals seldom maintain an adequate reserve for depreciation. Therefore the need for replacements, the urge to keep pace with modern scientific discoveries and inventions, the necessity of paying off mortgages and other debts when expansion has run ahead of capital, the desire for endowment to underwrite expansion and to serve as a bulwark of safety and security against the uncertainties of the future, all unite in pressure for an almost ceaseless and enormous in-flow of new capital. It has been estimated that the need of the hospital for new capital is almost twice as great as its need for current contributions.

Community chests can aid little in situations of this kind. They are devoted and adapted almost exclusively to current financing. Capital financing requires a different technique and a different appeal. While there is a normal flow of capital gifts and bequests developed through current giving, this is altogether too slow for the necessities of the hospital. Aggressive campaigns for current support unquestionably interfere with aggressive capital campaigns, and vice versa. Community chests are devoted to the former. The modern hospital, along with the modern university and other scientific institutions generally, has chosen to emphasize the latter. Thus there may be temporarily a conflict between the two interests, although in the long run they probably support and strengthen each other.

Large Cities Overhospitalized

If there is temporarily a conflict of interests at this point, I am not sure but that community welfare in a broad sense will be better served if the hospitals are forced to yield. We have been afflicted with too many capital campaigns and too much building. At the present moment and for several years past hospital capacities in our large cities, that is, the nongovernmental hospitals, have unquestionably been overbuilt particularly in their higher priced rooms. If we consider present business conditions and probable future needs, this is especially true.

Under ordinary circumstances, the only just reason for hospital endowments is to maintain free or part-free service or special research or experimental projects which may be generally

beneficial to mankind. They should not be used to make up general hospital deficits. Such use may only encourage lax and inefficient management.

Hospital accounts should be so constructed and so easily understandable as to make clear what the income and the cost in the various grades of service actually are. Endowment and contribution income should be credited only to patients and activities properly carried at community cost. The lack of uniformity and clear or accurate accounting in these respects is another reason why community chests have difficulty in contributing to hospitals. Uniform and accurate accounting will help the hospital to present clearly and forcefully its valid claim, whatever valid claim it may have, for public support, whether that support is to come in the form of current contributions, or income from endowment, or through payments from public tax funds.

Hospitals That Have No Claim on Chest

The establishment of new hospitals by new groups entering the hospital field in the last twenty years has resulted in overcrowding the field and in under use of the beds, with embarrassment to all managers. In addition to this most hospitals have engaged in programs of rapid expansion. If the new hospital is erected by some fraternal or religious order for the particular benefit of its own members and the order has sufficient financial backing to guarantee success of the project, there can be perhaps no just complaint, although the case would be clearer if there were clear need for the additional beds. But when such hospitals are started on a shoestring in a field where there is clearly no need for additional beds, then the results are likely to be unfortunate if not serious. Although established and incorporated as charitable hospitals these new shoestring institutions are seldom able to do any organized charitable work. Nevertheless when earnings prove scarce they come seeking charitable endorsement and the right to participate in charitable contributions and gifts.

Only those private hospitals that have in the past accepted as their responsibility service to the indigent sick on an organized basis and have cooperated with social agencies to that end can properly be considered for participation in a community chest.

The community chest is a modern method of helping to finance and support charitable service to the poor. Its primary concern is the support of private charitable agencies whose entire service is devoted to the poor. Few modern hospitals fall entirely in that classification.

The community chest, again, is a cooperative effort on the part of participating agencies to raise

most or all of the money which they need from contributions to maintain their charitable service. It is only indirectly concerned with other agency financial problems. Nevertheless it is concerned, for where there is a division of interests and responsibility the chest must know precisely how to measure the responsibility for care of the poor.

The chest, in a large community, deals with a wide variety of agencies. Many of these measure up to standards of service and of business methods which the chest may regard as acceptable. Some agencies in the chest do not do so and must be brought up to standard. Still others seek admission. In fairness to all these, for the protection of standards rather than their destruction, and in fulfillment of its trust responsibility to contributors it becomes necessary for the chest to exercise a considerable measure of control over the budgets, hence over the activities of all participating agencies. It is doubtful, from the standpoint of both the chest and the hospital whether such control in the case of the hospital with its complex mixture of business and charitable interests is desirable or possible.

The relationship of the community chest to its participating agencies has generally been understood to imply full responsibility of the chest for the budgets which it has approved and over which it exercises control. There is some question as to the permanency of this principle but even with considerable modifications such responsibility of the chest to a hospital which combines large business interests and earnings with its charity and which may therefore incur large deficits not due to charity would certainly be unreasonable and illogical as well as impossible.

How the Fund Functions in Chicago

The Community Fund in Chicago, first organized in 1930, has from the beginning dealt with approved charitable hospitals on a contract basis, agreeing to pay a certain per diem price (now \$3.75) for each hospital day's care of patients sent to them by the private family service agencies. There is a similar contract for clinic service at 65 cents a visit. Thirteen hospitals and ten clinics (of which five are independent clinics, the others being departments of the included hospitals) are now participating in this arrangement with general satisfaction to all concerned. The price paid by the fund does not cover and is not supposed to cover the average cost for the services rendered. It is presumed to cover and probably does cover the additional cost of service to the additional patients. The contract includes not only routine service, but medicines, laboratory tests, x-ray examinations and other "extras" of a regular nature.

This arrangement with the hospitals is based on the principle that the hospitals concerned are able and obligated to give some free service and our compensation enables them to maintain or expand the volume of that service. It also enables the private family service agencies to secure prompt and regular admissions of patients requiring free hospital or clinic service even during a depression, when the hospitals' ability to render such free service is impaired.

Only a Deficit Draws a Grant

To guard against payments for service which the hospital should carry at its expense, our contracts provide that our payments will be made only to the extent that there is an actual deficit in the hospital's current operating account. The rule is being interpreted broadly to allow for necessary interest and maintenance charges, but not for depreciation or extensive alterations or repairs, especially in the case of endowed hospitals.

Even on this limited basis, our payments to the hospitals and clinics on our list have averaged about \$250,000 a year for the last three years, which compares quite favorably with the amounts paid for free service in a much larger number of hospitals and clinics in the United Hospital Fund of New York City. This \$250,000 has been about 8 per cent of our total fund. Our hospitals in Chicago have not been deprived, however, of their right and ordinary custom to obtain contributions directly through their own efforts, a practice which they have continued with vigor and, in some cases, with more than usual success. Thus our payments have represented additional contributions.

Over and above our own payments to hospitals and clinics we helped to obtain for the same group an almost identical contract between the approved hospitals and the Illinois Emergency Relief Commission. These payments for the fiscal year ending September 30, 1934 will aggregate about \$650,000 and estimates for the next year run in excess of \$850,000.

Such subsidies from public funds to private hospitals, even in payment for specific service rendered, are likely, if long continued, to prove injurious to private philanthropic hospitals and should be regarded merely as a convenient or necessary stop-gap in a serious emergency. Such public subsidies rapidly dry up the sources of private contributions both for current support and for endowment and capital gifts, and the private hospital or other private charity that allows itself to become dependent upon public support will soon cease to hold its own castle or to manage its own household.

On this phase of community planning and hos-

pital finance let me quote an apt paragraph from a statement by Harry L. Lurie in *The MODERN HOSPITAL* of July, 1934:

"One of the basic principles of public service is that administration and financial support should be concentrated in the same agency, and that the performance of a function without administrative control or the reverse leads to many problems which lower efficiency. Since we are dealing with a continuing problem it is important, therefore, that government units under their own auspices should develop a comprehensive program of hospital services. Various expedients, such as contracting for services with voluntary hospitals, should be considered as temporary measures pending the development of an adequate government hospital program."

Let me add that private philanthropic hospitals should proceed as speedily as possible to work out their own revised programs to fit the new conditions of the times into which we are emerging, if they would continue as independent and autonomous institutions.

Little Uniformity in Practice

Present day practices of community chests the country over in relation to hospitals show little uniformity. The supposedly standard practice or policy of the standard community chests to underwrite all budgets of all participating agencies, including hospitals, has been neither practiced nor practical. This policy was being modified before the depression began and modifications have been more marked since.

Data furnished by the national organization of Community Chests and Councils show that in 1933 sixty chests gave \$2,111,385 to hospitals, or a little more than 10 per cent of their total funds. This \$2,111,385 represented approximately 16 per cent of the total receipts of the hospitals concerned. The figures given do not include Chicago. But of these sixty chests, twenty-nine gave to hospitals nothing at all. In 1934 the same chests are giving toward the support of hospitals \$1,982,000, or less than 15 per cent of their estimated total receipts, the community chest contributions representing a little less than 10 per cent of their estimated total funds. Thus hospital receipts have increased, doubtless because of government subsidies, while the contributions from chests are declining, both actually in terms of dollars, and proportionately in terms of hospital needs and community chest resources. This drift apart will probably be accelerated in the coming years, for the two centrifugal reasons that hospitals can and are drawing increased proportions of their needs, in so far as charitable service is concerned, from government

sources, while community chests must conserve their declining resources for the maintenance of charitable services that cannot be financed by the government.

There is also a tendency to change the base of relationship from that of full or shared budget responsibility to a limited contractual base such as we have adopted in Chicago.

Competent chest executives are saying today that the chests are not justified in turning any part of a community's contributions for charity over to any general hospital except in payment on a limited basis for a limited amount of service rendered to the clients of private charities, or for limited experimental purposes. It is doubtful, under conditions that seem to be developing, whether the hospitals should continue to expect any large share of voluntary contributions for their current maintenance under any method of solicitation, chest or otherwise.

Where, then, shall they look? The answer proposed is, to earnings. Let hospitals be conducted primarily as business institutions not for profit. Let them render service primarily and almost wholly to people who can pay for private hospital service either out of their purses as they need it or through group insurance set up on a large scale and maintained through gradually accumulated reserves.

Regular Income Is the Goal

If the New Deal or the seeming tendencies and demands of the times result in some redistribution of wealth, we may have fewer individuals with large accumulations of surplus out of which to make lavish contributions and capital gifts and bequests, and vast numbers of people who are able to pay under well regulated plans for the modest hospital services they require. Assured payment for uniform service should make possible some very material economies in hospital costs. Thus the means of the patient and the end of good hospital service may be brought closer together, may be united entirely in so far as all routine service is concerned. Research, experimentation and a relatively small amount of charitable service may be maintained through a reduced flow of gifts and endowments which, we may assume, will not cease altogether.

Thus is indicated what many conceive to be the field of the philanthropic hospital of the future. It is presumed that the great bulk of charitable service, whatever need for it there may be, will be provided in hospitals, owned, operated and maintained by the government.¹

¹Read at the Institute of Hospital Administrators, University of Chicago, Sept. 13, 1934.

Management Problems of Small and Moderate Sized Hospitals

By BENJAMIN IRA GOLDEN, M.D.

Superintendent, Davis Memorial Hospital, Elkins, W. Va.

IT IS difficult to evaluate the factors that determine true efficiency in hospitalization. In an effort to be of service to smaller hospitals in efficient management, a brief survey by questionnaire has been made of hospitals up to 125 beds in three states — Ohio, Kentucky and West Virginia. This article represents a summary of the findings.

The majority of American hospitals are small. Sixty-eight per cent of the hospitals in Ohio have a capacity of less than 125 beds, and in Kentucky and West Virginia 76 per cent of the hospitals have less than 125 beds. When the individual questionnaires were returned and the charting of information began, it was the daily patient average rather than the bed capacity that was used, for the daily occupancy figures represent the actual value of hospital service to the community and should be the barometer of management.

Returns on the questionnaire indicated a real interest on the part of hospitals in management. To Ohio were sent 50 questionnaires, 78 per cent of which were filled out and returned. Of the 19 sent to Kentucky, 48 per cent were returned, and of the 27 questionnaires reaching West Virginia hospitals, 67 per cent were returned. The questionnaire was divided into two parts, one dealing with the scientific care of the patient and the other with routine problems of management.

The smallest hospitals seem to be suffering most from lack of patient support in each of the three states. Hospitals of less than 25 beds reported an occupancy of 41 per cent, 23 per cent and 35 per cent, respectively, in Ohio, Kentucky and West Virginia.

Those institutions having from 25 to 50 beds were a little more than half occupied, the figures being 52 per cent, 51 per cent and 60 per cent for the three states.

In Kentucky hospitals falling in the 50 to 75-bed class were running at 81 per cent of capacity. The other two states were not so fortunate, Ohio hospitals of this class having an occupancy of 61 per cent and those of West Virginia of 59 per cent.

The larger hospitals among those studied, that

KENTUCKY



IN KENTUCKY THERE IS ONE
NONPROFESSIONAL EMPLOYEE
FOR EVERY FOUR PATIENTS.

is, those from 75 to 125 beds, showed an occupancy of 58 per cent in Ohio and 78 per cent in West Virginia.

From these figures it is evident that hospitals today are burdened with physical equipment from which there is no return.

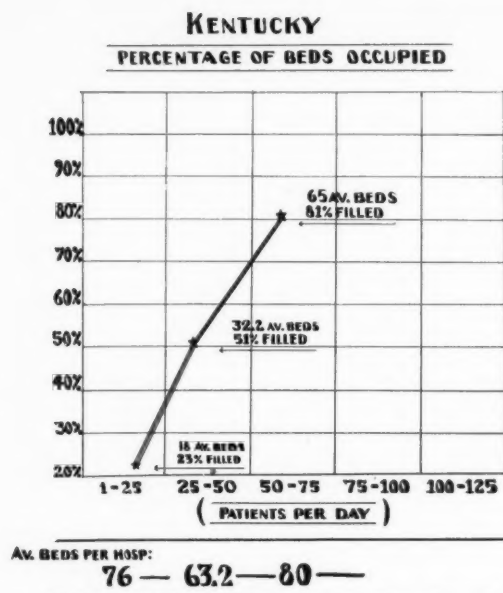
Another factor studied was the relation of nursing personnel to the daily patient average.

In Ohio one hospital averaging 35 patients per day has forty nurses, including students and undergraduates. Another hospital having 50 patients has 44 nurses. At the other extreme one hospital averaging 40 patients has five nurses. The Ohio

WEST VIRGINIA



IN WEST VIRGINIA THERE IS
ONE NONPROFESSIONAL EMPLOYEE
FOR EVERY TWO PATIENTS.



average at the time the questionnaire was answered was one nurse to every 1.1 patients.

In Kentucky the average was one nurse to 2.7 patients, and in West Virginia the average was one nurse to every 1.5 patients.

While Kentucky has no schools of nursing in institutions of less than 25 beds, in Ohio half of the hospitals of less than 25 beds that answered this questionnaire conduct schools of nursing and in West Virginia 60 per cent of the small hospitals have schools. Only 40 per cent of the West Virginia schools of nursing in this group have an instructor in nursing.

Among the hospitals having from 25 to 50 beds, 69 per cent in Ohio have schools of nursing, 68 per cent of which have instructors. In Kentucky in the twenty-five to fifty-group 60 per cent have schools of nursing and all have instructors in nursing. In the same group in West Virginia half of the hospitals run nursing schools and of these schools only 25 per cent have instructors.

All of the hospitals of 100 to 125 beds replying to the questionnaire conduct schools. Special instructors for the students are provided in Ohio and Kentucky but in West Virginia only half of the schools in these moderate sized hospitals have instructors in nursing.

In the hospitals answering the questionnaire Ohio has 1,002 student nurses and employs 496 graduates. Kentucky has 88 students and employs 50 graduates. West Virginia has 257 student nurses and employs 177 graduates.

While, of course, the foregoing picture is not accurate for the three states as a whole, yet the replies take in a large enough group of institutions to place the nursing situation squarely before us. When we consider that these hospitals employ only

one graduate for every two students in training, it is apparent that, far from alleviating the oversupply of nurses, the hospitals represented are rapidly making the problem a more serious one.

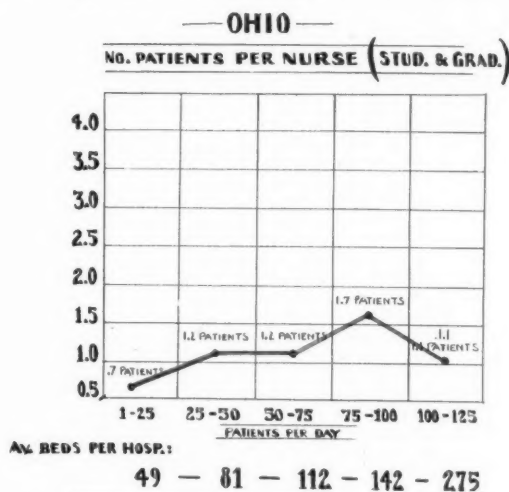
Let us now take up that part of the questionnaire that deals with the household and maintenance departments.

In the hospitals studied in Ohio and West Virginia it was found that on the average there is one nonprofessional employee for every two patients. The ratio for Kentucky is one nonprofessional employee for every four patients.

In the matter of nonprofessional employees come tremendous variations in hospital management. One hospital has one employee for every 0.8 patient, while another has one employee for every 5.3 patients. The conclusion from this part of the questionnaire must be that some hospitals are either misusing their undergraduate nurses for maid service or the patients are being sadly neglected. In either event the institution is not justified in its action.

One question had to do with laboratory rates. The number of hospitals that either failed to answer this question or stated that they had no flat rate was surprising. A flat laboratory rate means more than an income to the institution. Laboratory facilities are one of the main reasons why the physician moves his patient to the hospital. If, because of the financial burden, the physician is limited in making use of the clinical facilities offered, the hospital fails in its duty. If, on the other hand, the hospital is not encouraging the widest use of its clinical laboratories, it is failing to bring about scientific medicine.

In Davis Memorial Hospital every patient admitted is charged a flat rate. Thus he obtains as a routine a urinalysis, complete blood count, Kahn test and, when indicated, blood sugar and non-protein nitrogen tests. The scientific advantages given the patient far outweigh the additional costs.



Furthermore, when routine tests are carried out techniques are developed that reduce the cost of laboratory procedures.

A question in regard to hospital printing was asked. Few superintendents had much knowledge of the subject. It is my belief that any hospital averaging fifty patients a day can save money by investing in a small multigraph press. By this means records can be turned out at less than one dollar per thousand copies.

Most hospitals are today doing their own laundry work. It is possible that with their lower daily occupancy many of them would find it more economical to use one of the small so-called "dry cleaners' drums" rather than the large heavy machines.

To the question "Do you buy your canned goods locally?" the answers varied. Some administrators felt that they could get better quality at home than from the factory; others said that they were compelled to buy at home to secure local support. Some believed they could obtain direct privileges only by buying in carload lots. It is evident that many of us are not paying sufficient attention to the salesman who appears at our door. We can buy direct in any quantities from houses whose specialty is No. 10 cans and frequently save as high as 30 per cent in our investment. Those superintendents who feel that they should buy locally should at least make a comparison of bids and ask their boards to increase the budget to take care of the net loss caused by local buying.

The telephone is as essential as the operating room, but it is a continuous drain on the hospital pocketbook. Too much has been taken for granted concerning telephone service and not enough investigation has been made.

Does Your Telephone Service Do You Credit?

The functions of hospital telephone service are several. The first is to receive outside calls. Approximately 90 per cent of these calls are to ascertain the welfare of a patient; therefore, they should be answered by an official of the institution. It is the haphazard answering of these calls that has brought hospitals into disrepute. A second function is for the discussion of the care of the patient between a staff member and an official. The third use is for business conversations with an official.

With rare exceptions it is not necessary that incoming calls be distributed to every nook and corner of the hospital. Outgoing calls, in the main, are carried on by officials or should be. There seems little reason for small institutions to pay large sums to connect the outside and house systems. Under the switchboard system, the board must be maintained twenty-four hours a day re-

gardless of the number of patients in the hospital or the business carried on. Would it not be better to have an interhouse system of the dial type which works twenty-four hours a day without supervision and at nominal cost? The outside communication would be carried on by the main office with a few extensions at vital points throughout the hospital.

Let us see how this might work. All intercommunicating telephoning is done directly through the dial system. An outside call comes into the office and is answered. It is found that the person wanted is at some point in the building. He is located through the house system and told to answer on the nearest extension. While this is not quite as easy as the switchboard method, the inconvenience certainly should not have a value of from \$75 to \$250 a month to the hospital.

Supervision of Supplies Sometimes Lax

While each institution, in replying to the questionnaire, stated that it had absolute supervision over its supply closets, it is questionable whether the supervision is really absolute. Recently in visiting an institution of moderate size I saw a nurse walking down a corridor with a handful of Luer's syringes. Upon being questioned she told me that she had just received her week's supply. This amount should have supplied the whole institution for a month.

Almost all hospitals reported a great saving in fuel by a twenty-four-hour-a-day heating system.

"Do you save personnel and facilitate routine by a complete daily schedule the evening before?" was a question that brought interesting replies. Many institutions report that the doctors will not cooperate in this plan.

With the exception of emergencies, nearly all work can be definitely scheduled and the time set the evening before. If this is done it reduces confusion, permits a more even routine and produces real savings by reducing the necessity for much duplicate equipment. That doctors will not cooperate is often due to the failure of the institution to explain to the doctor the value of such a routine both to himself and to the institution. If the physician knows that his equipment will be ready at an appointed time and that he can thereby reduce the length of his hospital visit, he will make an effort to cooperate. Hospital managers can well spend more time in acquainting the medical staff with some of the hospital's financial problems.

The most important question in the questionnaire was, "How do you collect your money?" The universal answer to this question was, "when and if."¹

¹Read before the Ohio, West Virginia and Kentucky Tri-State meeting, April 17-19, 1934.



Nose and throat examining room. Flush rim dental sinks, air, vacuum and individual table equipment were installed.

Two Old Structures Make a Modern Out-Patient Building

By WILLIAM GEHRON
Architect, New York City, and

JOSEPH TURNER, M.D.
Director, Mount Sinai Hospital, New York City

MODERNIZATION of an old hospital building entails both pleasure and despair. The pleasure comes from devising ways of reclaiming areas that are awkward in design and from seeing the old building altered magically into one that compares favorably with those of modern construction. The despair settles down thickly, however, when we encounter the limits imposed by existing fenestration, by fixed stairs and elevators, by immovable steel girders and columns, by unalterable ceiling heights, and by differences in floor levels when adjoining buildings are to be combined.

These elements create a strait-jacket of inflexibility offering at first glance little chance for escape. But as obstacles are overcome one by one and as solutions are eventually found for all problems, an end result is finally achieved that satisfies a sympathetic albeit critical medical staff and pleases a practical building committee. And before lending its approval to the project, this experienced building committee carefully compares the relative merits and costs of the proposed alteration with those of a new building, freely planned and designed, and limited only by restrictions of site, of relations to adjoining buildings and of funds.

The modernization of the old out-patient building of Mount Sinai Hospital, New York City, is a case in point. Here was a building planned in 1900 as an out-patient department in a group of ten buildings constituting a general hospital of 400 beds. It was one of the few clinics constituting part of a general hospital to be found at the turn of the century. The facilities it provided in a three-story and basement building seemed liberal in view of dispensary practices at that time.

Although it was expected to serve many years without expansion, its capacity was soon taxed and a few years later two more floors were added. Even this was found to be inadequate in less than a decade to meet the increasing needs of a thickly populated metropolitan area housing hundreds of thousands of persons in the lowest wage earning groups. Many shifts and temporary expedients were adopted over the years to meet these needs, but it was long evident that it would be necessary to plan for a substantial increase in the facilities for dispensary service to achieve real results.

The recent development of the general building program of the hospital, including the moving of the school of nursing to a new building, freed the old nurses' home adjoining the dispensary, thus making possible a plan for lateral expansion. Here arose the first serious problem — that of connecting and using as one two adjoining buildings with different floor levels; wide variations in ceiling heights; a solid, heavy, unpenetrated masonry fire wall completely separating one building from the other, and interior arrangements as varied as the totally different purposes for which the two buildings had been designed.

There were other functional problems with respect to the location and relation of stairs, elevators, exits, lines of traffic, accessory services and other matters. Many and varied means were employed to solve them, but it is sufficient to say that the two buildings were connected and the lower four floors and the basement of the eight-story nurses' home were converted into an annex joined to the main clinic building. Both buildings were rebuilt over a period of two years without interrupting the clinic service for a single day. Today the renovated and expanded clinic leaves little to be desired from a standpoint of sound administrative control and comfortable medical facilities to carry on its essential functions.

The original out-patient building is an oblong structure, 50 by 100 feet, with a single stairway and elevator next to the wall separating it from the adjoining former nurses' home. The latter is an irregularly shaped building, 100 feet in length, with three wings as in a letter E, the long arms returning for 60 feet, with an elevator and stairway placed in a short middle stem.

By maintaining this shape and clearing away some partitions of inside rooms on either side of the central stairway, the floor divided itself naturally into two clinic groups, each with an inner waiting room, adequately ventilated by outside windows, opening into an outer fringe of rooms formerly used as a nurses' dormitory, but now

converted into clinic offices, examining and treatment rooms. While the central stair and elevator were serviceable, the position of the stair and elevator in the old dispensary building next to the dividing wall was a happy circumstance, for it allowed this single stairway and elevator to serve both buildings through connecting passageways with short flights of steps to correct differences in floor levels. The other elevator and stairway were reserved for emergency uses.

This modernization program included some new construction. A low one-story and basement pharmacy was built in a court in order to free additional waiting and record room facilities needed on the main floor. The pharmacy has a dispensing window opening directly into the first floor waiting room. This construction also included a covered ramp providing direct passageway between the first floor of the out-patient department and the ground floor of the main hospital group where the admitting ward is situated. It also provided a sheltered ambulance entrance permitting direct transfer of patients under cover from an ambulance into the admitting ward. Overhead a bridge connecting the upper floors of the main group with

This fourteen-foot corridor serves also as a waiting room, with examining and treatment rooms on each side. The floor clerk stationed at the elevator and stairway controls the patients and the record conveyor system behind her.



the out-patient department was built permitting direct access at this upper level to all of the buildings in the main hospital group.

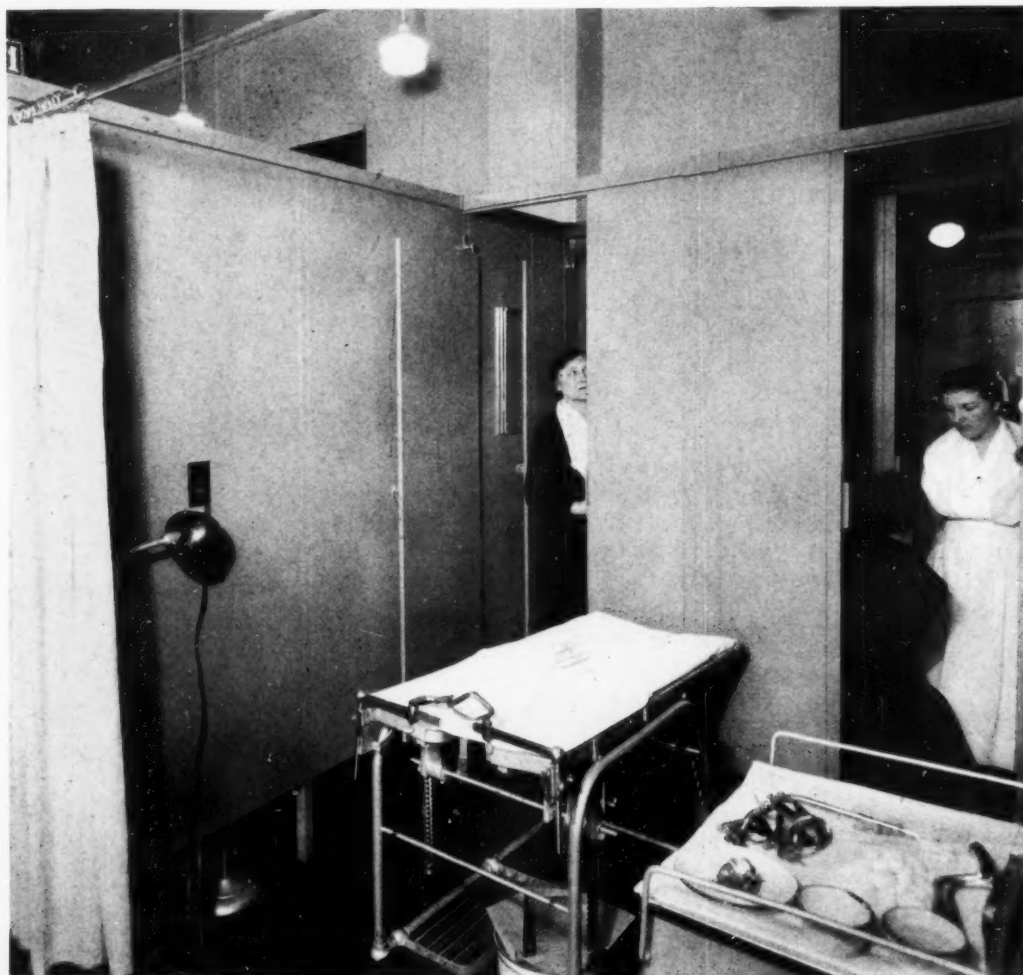
Apart from the new pharmacy, the first floor of the old clinic building is now given over entirely to administrative and admitting offices, waiting spaces for old and new patients, examining rooms for medical classification of new patients, and accessory janitor closets and toilets. The location of these various offices, in relation to the stairs and the entrance, is such that new and old patients are automatically separated. Patients with or without appointment, those waiting for drugs, and those waiting for medical classification do not cross lines in moving from one to the other. To take care of the long waiting line when the cashier's cage is open, a maze is provided permitting a line of patients 60 feet long to be handled within an area 15 by 11 feet.

The dispensary record room is in one corner behind the cashier's cage. Direct connection is provided with an adjoining room in the annex in which are housed the in-patient records. The juxtaposition of these two record rooms permits the development of a single central record room for

both in-patients and out-patients. Connection is maintained with the several clinic floors by endless belt mechanical conveyors, by means of which patients' records are sent up and down.

The practicability and need of consolidating all out-patient and in-patient clinical records in one room or as one unit have not been convincingly demonstrated here or elsewhere. The present plan, therefore, allows in-patient and out-patient records to be kept separated in these two rooms, but for all practical purposes it may be considered that groups of records are housed in a single department. If it is found desirable at a later time to combine as a unit in a single location records of a patient for whom both hospital and out-patient department charts exist, the location and relation of the rooms permit this to be carried out easily.

The new record room in the clinic building is equipped with metal letter files; the annex record room is provided with stacks of steel shelving arranged in two levels, a floor and a balcony, the latter reached by an inside circular stairway. The height of the top shelf in each level does not exceed eight feet, so that persons of average height can reach charts on upper shelves without a ladder.



Gynecological clinic. View of individual cubicle showing relation of two dressing booths with separate access to patients' corridor.

Apart from the stack room are an office and workrooms for the record room clerks. Across the hall in the library a section has been set apart for the use of the medical staff to permit study, research and investigations requiring reference to clinical charts.

Charts of clinic patients are filed in the out-patient section of the central record room. The mechanical conveyor system moves the records from the record room to the clinic floors, each of which is provided with a station to receive and dispatch records. With the medical staff making full use of an appointment system, it is possible to send the records of patients, returning by appointment, to clinics in advance. Charts for new patients are prepared on the first floor and reach the clinics within a few minutes on the conveyor. Charts of patients transferred from one clinic to another are routed through the central record room to the new clinic by means of the conveyor. Each clinic patient has a single chart and a single number, irrespective of the number of clinics attended. The chart accompanies the patient to all clinics and contains, in a single folder, the complete medical life history of the patient.

Each clinic floor has a central corridor fourteen feet wide extending through the long axis of the building. This corridor serves also as a waiting room for floor patients. It is flanked on either side by the clinics. It is entered at one end from the elevator or stairs and is controlled at this point by a floor clerk stationed at the chart conveyor station. The corridors are connected by an exhaust ventilating system. All corridors have outside windows for natural ventilation. Toilet facilities for patients and staff, porter closets, chilled drinking water and clocks operated from a master system are found in each corridor.

The second floor in the main building is given over entirely to the clinics for surgery and orthopedics. The surgical clinics consist of a central or common office leading on either side to large examining rooms for male and female patients. Cubicles are provided for patients requiring exposure. A completely equipped operating room with accessory sterilizing and recovery rooms adjoins one of these rooms. The orthopedic clinic on the other side of the waiting corridor has also a centrally placed office leading to a plaster room and a number of separate examining rooms.

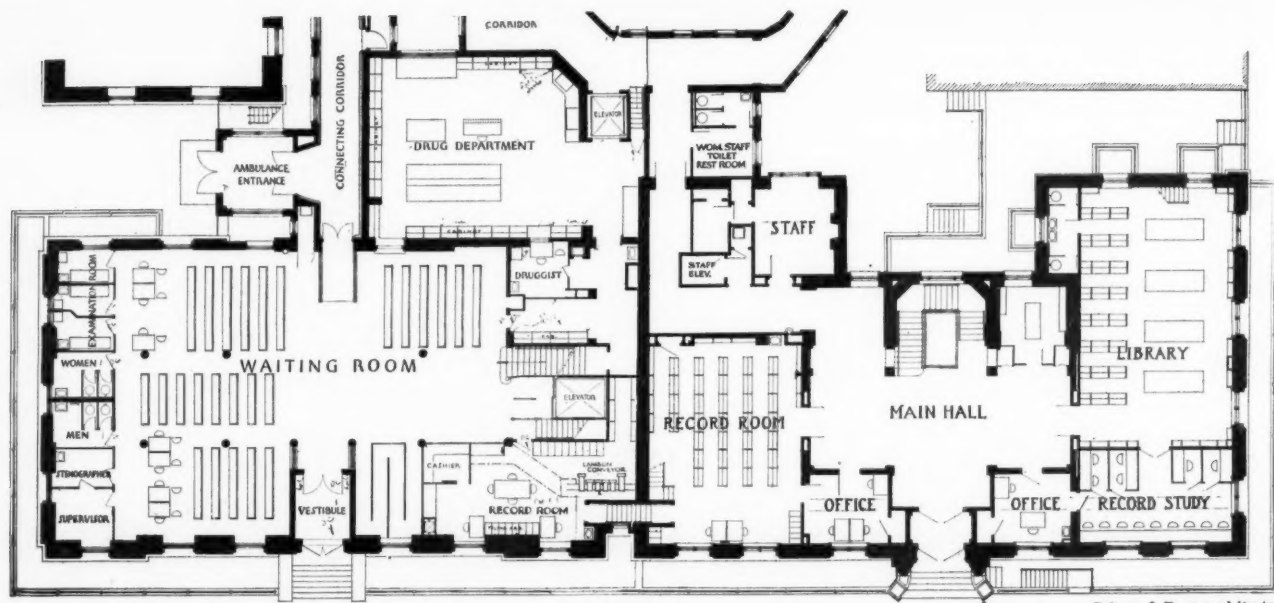
The third floor provides facilities and equipment for the ear, nose and throat clinics. The improvements included installation of flush rim dental sinks and of air, vacuum and individual table



Gynecological clinic, showing nurses' and doctors' inner service corridor.

equipment. The genito-urinary rooms, at present limited to male patients, are arranged so as to permit the admission of female patients if the character of this service changes in the future. A separate venereal room with venereal sinks is provided. The gynecological clinic has been planned with improved facilities for privacy and service. These include separate toilet and dressing facilities, history taking cubicles and a small laboratory. The two-corridor arrangement of the examining cubicles permits free movement of physicians in one corridor and nurses and patients in the other corridor, without crossing of lines or sacrifice of privacy.

The medical clinics occupy the entire fourth floor with provision for a central office, fluoroscopy room, twenty-two history and examining cubicles and a large laboratory for clinical microscopy. Staff movement from room to room is facilitated by inner history-taking corridors. Adjacent to the medical clinics and reached by a few steps is a dietary classroom, 37 by 18 feet, equipped with pantry sink, stove, demonstration table and chairs for pa-



Layout of the first floor after remodeling. The main clinic building is at the left, and the annex at the right.

tients referred from the metabolism and other clinics for dietetic instruction.

The fifth floor is shared by the eye and skin clinics. Both have central controlling offices. In the eye clinic this office leads to a group of examining, treatment and dark rooms. The skin clinic, like the surgical clinic, has large, well lighted rooms for men and women, with many curtained dressing and examining cubicles. In addition, there are separate facilities for x-ray and physical therapy, salvarsan therapy, a small routine laboratory and an operating room for biopsies.

The basement of this building contains part of the pharmacy manufacturing laboratory, lockers and toilets for employees, record room storage, space for liquors and alcohol, and an outside vault with fire protection features for inflammable and explosive drugs.

In the adjoining annex, half of the ground floor is allocated to the out-patient social service depart-

ment. A large waiting room leads to many offices of social workers and to a conference room for groups. A separate street entrance permits access to these offices independently of the admitting routine of the out-patient clinical services.

The other half of this floor is occupied by a general follow-up clinic. It is used by all in-patient services at definitely scheduled periods, for follow-up of end results in ward or service cases not referable to the out-patient clinics for further treatment. The department includes a waiting room, a medical staff office, a secretaries' office, and separate examining rooms for men and women. The last are subdivided by curtains into cubicles and are provided with appropriate equipment, sterilizers, scrub-up sinks and laboratory facilities. The separate street entrance already referred to also serves this department without causing interference with the regular clinics.

The first floor of the annex houses the medical



Facilities for the ear, nose and throat clinics are on the third floor. Main building (left) and annex (right).

library. The main reading room is 25 by 60 feet with stacks along one wall arranged in two levels, an inside stair reaching the balcony. An adjoining alcove contains stacks for current medical journals. Several comfortable reading tables are placed in the main reading room, part of which is closed off to provide study or work cubicles. The ceiling is treated acoustically. An adjoining office is provided for the librarian.

The dental clinic occupies several rooms in the southwest corner of the second floor of the outpatient annex. The shape of this area permitted its alteration into an effective communicating group of rooms with plenty of natural light and

cabinets for the dark room are arranged to be accessible without light leakage from both sides, the viewing room as well as the dark room, thus permitting wet films to be examined promptly.

On the third floor are the expanded out-patient physiotherapy rooms and the clinics for neurology and mental health. The former consists of an office leading to large treatment rooms for men and women patients with curtain cubicles for privacy. Another room on the third floor is equipped with seven-foot obscure glass and steel partitions for individual examinations and treatments requiring exposure.

The neurology and mental health clinics occupy



First floor waiting room, showing cashier's cage and record room, above which is the record conveyor.

ventilation. Five dental operating chairs with cuspidors are separated by metal partitions. Simpler chairs are used for x-ray examinations and for dental inspections. A small dark room fully equipped for developing x-ray films adjoins the operating cubicles. A workbench for preparation of various dental appliances and indentures is also provided. Nearby is a tiled operating room for oral surgery, extractions and other dental operations requiring administration of anesthetics to patients lying down. The entire layout allows for a maximum of service with a minimum of personnel and effort.

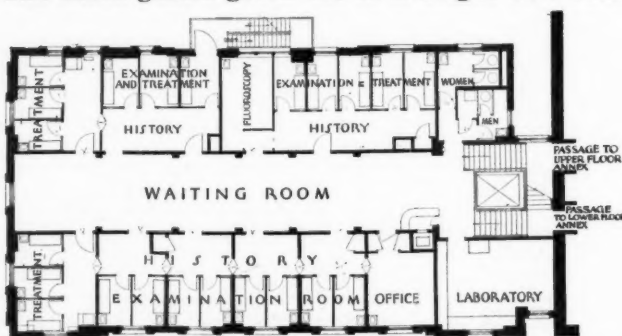
At the other end of the second floor is the outpatient division of the x-ray department, consisting of two lead lined radiographic rooms, a fluoroscopic room, an office and waiting room, a viewing and filing room and a dark room. The specially designed heated and ventilated drying

the other half of the third floor. In addition to the waiting room and office, the department provides six individual examining cubicles reached by an inner corridor, a large examining and special treatment room, and a still larger room equipped for occupational therapy. A folding door separates a clinical laboratory which, when opened wide, makes a large conference room.

The terrazzo floors in the original corridors were not altered. The floor of the waiting room on the first floor was resurfaced with six-inch red quarry tile spaced with $\frac{3}{8}$ -inch black joints. The nose and throat and surgical operating rooms were refinished with a green vitreous tile floor, while the floors of toilets and janitor closets were finished with ceramic tile. The floors of the few clinic rooms showing evidence of much patching were resurfaced with asphalt tile laid in pattern upon

the old floor. Linoleum was used for the floor of the x-ray therapy room because its broad unbroken area provided better protection.

Walls in the waiting corridors were protected by wainscoting 4 feet 6 inches high of oatmeal tile $4\frac{1}{4}$ inches square. The same tile was used for toilets and utility rooms, the latter being tiled to a height of 5 feet 6 inches. Walls of the operating room and nose and throat room were surfaced with dull finish glazed green tile to a height of 7 feet.



Fourth floor of main clinic building. This entire floor is occupied by medical clinics.

Plaster walls were covered with buff or ivory enamel.

Chief dependence for ventilation of the waiting rooms was placed upon the outside windows. Supplementing this was an exhaust ventilation by fans on the roof. In a few clinics separate exhaust systems, locally controlled, were installed. Separate ventilators were also placed over the sterilizers in the operating room and over the percolators and the manufacturing counters of the pharmacy.

All of the floors and clinics were wired for alternating and direct current. Electrocardiograph lines are accessible at various points. Clinic services requiring the use of gas, compressed air and vacuum were fitted for these at convenient points. The physicians' call system was extended with light and auditory signal boards where needed. Because of the distance from the central refrigerating plant, the few refrigerators needed in this building were units with self-contained compressors. All hardware was chrome plated.

The fixed partitions within the rooms are of metal and glass, the metal parts made of plain panels without dust catching trims and moldings. The curtain cubicles in a number of clinics are of a modern type, extended from an overhead track and operated on rollers like a shower curtain. Clocks connected with the central master clock were liberally provided. Lighting in the examining and treatment rooms of the eye service is supplied by specially designed indirect fixtures. X-ray therapy rooms were lined with $\frac{1}{4}$ -inch sheet lead

in walls and $\frac{1}{8}$ -inch in floor. Shelving and counter equipment in the pharmacy is of steel and shelves are covered with asphalt tile. Steel lockers are provided in the basement for employees of both sexes.

The original contracts were let for more than \$350,000 exclusive of architects' fees or engineers' fees. This figure represents two alteration contracts, both awarded to the same contractors and covering two years of work. The alterations covered the items described briefly in the article, as well as two new elevators, a new construction for the drug room in its basement and connecting passageways, a new vault for inflammables, outside fire exits, fire walls, and the entire renewal, with new material, of ventilating, plumbing, heating and electrical lines. In addition, four floors of the annex building were converted into resident quarters for a house staff of more than fifty men.

The cost of equipment, \$40,000, represents only the additional equipment bought for the expanded activity of the department. Practically all the old equipment was refinished and is equal to new.

Architects for the building were the firm of Gehron and Ross; engineering consultants for heating, plumbing and ventilation were Tenney & Ohmes, and consultants for the electrical equipment were Kaiser, Muller and Davies, all of New York City.

How to Fight Fires

Practical suggestions on the use of fire extinguishers were made by C. B. Langdon, chief engineer, Factory Fire Insurance Association, Hartford, Conn., in addressing the fifth annual Greater New York Safety Conference.

In attacking fires in ordinary combustibles, fires on floors are extinguished by directing the stream at the base of the flames nearest the operator and following up as conditions permit, Mr. Langdon said. Fires in a pile of wood or stock or in a wall or partition are best attacked at the bottom, following the flame upward so as to prevent the possibility of rekindling.

Fires in most flammable liquids can be extinguished by smothering with foam, carbon dioxide or special dry chemical extinguishers. In the case of carbon dioxide or special dry chemical extinguishers the discharge should be directed at the burning liquid, but with other types it should be directed against the opposite wall of the container above the liquid level. It should then be manipulated from side to side unless the container is overflowing, in which case direct application is necessary. Direct application is also needed for pools of oil on floors.

Sand is effective for smothering small oil or grease fires on floors. Carbon dioxide and carbon tetrachloride extinguishers are most effective on electrical fires and result in minimum damage.

There are a few unusual problems, for example, water and water solutions cannot be used on chips of aluminum or magnesium as water intensifies the blaze. This has to be smothered with sand or similar granular material.

Los Angeles Clinics Meet Standards

A number of Los Angeles clinics continued to receive Community Chest funds even after they failed to make changes recommended by the Community Welfare Federation. That was before 1930 when new standards for plant, equipment, administration and medical social service were adopted. Federation financial support has since been withdrawn from four clinics. Today, the rest either meet or surpass the accepted standards

By MARY STANTON

Secretary, Child Welfare and Health Divisions,
Los Angeles Council of Social Agencies

many of the medical staffs were a long way "behind the clinics." One doctor described the local clinic development as follows: "A few people get together, rent a building, hire a worker, buy a car, and then announce that they have a clinic." In some clinics, the patients were frequently attended by the nurses, as physicians repeatedly failed to arrive. Nurses in certain clinics were also compounding medicines, contrary to state law.

Finally the health committee realized that the same recommendations regarding the clinics were made year after year, and that many agencies disregarded them and still continued in the federation.

In 1929, the Council of Social Agencies was established as a department of the Community Welfare Federation. One hundred eighty-two social agencies and departments, voluntary and tax-supported, constitute the council membership. Of the thirty-one health agencies, eight are voluntary agencies entirely supported by private funds, fourteen receive partial support from the Community Welfare Federation, and nine are tax-supported public departments and institutions.

How the Committee Operated

Following the organization of the council, the health committee was reorganized with a membership composed of representative doctors, nurses and medical social workers selected from the voluntary and tax-supported health agencies. The first action of the health committee of the council was directed toward a revival of interest in the health survey. A voluntary non-Chest health agency offered to finance, in a large measure, a health survey, provided its scope would cover all health agencies in the community. Objections of some representatives of the public agencies made the survey impossible at that time.

The health committee then decided to agree upon a platform that could be accepted by the Commu-

WHEN the Community Welfare Federation of Los Angeles was organized in 1925, plans were made for surveys, according to functional classification, of the member agencies receiving financial support. After the child welfare and family fields had been surveyed by national organizations, the plans for the survey of the health agencies were dropped because of financial reasons.

Members of the functional committees of the federation annually visited member agencies receiving financial support, in order to evaluate their work and recommend continuance or discontinuance for the ensuing fiscal year. If the agencies were to be continued, they might be commended for outstanding achievements or recommendations might be made for changes. If the recommendations of previous years were not met, conditions could be set which the agencies would be required to meet if they wished to be continued in the federation and receive funds from the Community Chest.

The first health committee had, as an aid to their clinic evaluation, six sentences listing certain requirements for clinic membership. One sentence provided, "There must be a medical staff behind every clinic." As the years passed, it seemed that

nity Welfare Federation as a basis for the operations of clinics receiving financial support. The clinics would be given copies of this agreement and allowed time to meet the requirements. Their work would then be evaluated on the basis of a common standard and not according to the varying measuring rods of the individual members of the health committee. To carry out this plan, a special committee began work on such a statement. The requirements for the physical plant and equipment were first evolved. Soon a second committee was formed to draw up standards for medical social work and, later, a third committee was organized to prepare standards for administration.

The chairmen of the three committees finally coordinated all of the contributions in a fifteen-page mimeographed booklet entitled "Standards for Clinics." In July, 1930, the standards were adopted by the health committee, by the executive committee of the Council of Social Agencies, and by the board of directors of the Los Angeles Community Welfare Federation. In June, 1932, the California Medical Association published this work in pamphlet form, under the title, "Standards of Clinics for the Indigent."

Some Requirements Set for Clinics

The standards classify and define clinics according to "attached" and "unattached," also "general, special and preventive." They state that clinics should be established to meet the needs of the community, should cooperate with public health authorities and social agencies, and should guard against abuse of the volunteer service of physicians. The requirements for physical plant are presented according to (1) accessibility, (2) distribution of various clinics within the plant, (3) examining rooms, waiting room, toilet facilities, operating rooms and similar accommodations. A section on equipment requires an adequate supply of instruments, suitable facilities for their sterilization, and pathologic laboratories, x-ray service and a pharmacy under the direction of qualified personnel. The section on organization prescribes an active board of directors, operating under an adopted constitution and by-laws and meeting monthly to transact business, and a qualified superintendent.

The staff is limited to licensed physicians in active practice competent in their specialties. Members are appointed by the directors on staff nomination and must be organized into a definite group with duly elected officers and monthly meetings. Regular attendance is required.

A social service department under a trained medical social worker is required as an integral part of every clinic. Staff members should be eligible

for membership in the American Association of Hospital Social Workers. The major activity of the department should be medical-social case work. Standards are suggested for office facilities, records, reports and the patient's social history.

A central filing system under the responsibility of one person is required. A brief outline of the scope of the clinical records, together with a system of reports and statistics, is given.

Each clinic was immediately furnished with copies of the standards. In 1930, and each succeeding year, the clinics were visited by members of the health committee and their work evaluated on the new basis.

When the standards were adopted, eleven unattached clinics and one out-patient department comprised the group receiving funds from the Community Welfare Federation. Since that time, four substandard unattached clinics, whose directors refused to merge with standard clinics or meet the requirements, were discontinued from the Community Welfare Federation. Two unattached clinics under the auspices of the same church merged and moved into quarters especially planned for them in a new wing of a Class A general hospital under the same religious affiliation. The clinic pays for a limited number of beds in this hospital. Another unattached clinic, under the direction of a cultural group, became the out-patient department of a new Class A general hospital erected by the same group. These two clinics are now in new locations that surpass the physical requirements established. Another unattached clinic, specializing in children's work, affiliated with a Class A general hospital on adjoining property and took over the children's ward in the hospital. One remaining unattached clinic was granted funds for limited hospitalization of its patients by the Community Welfare Federation beginning November 1, 1933, and is now able to complete plans for affiliation with a Class A general hospital.

Large Gains in Social Service Work

In one instance, in which a hospital specializing in children's care was operated by a male board of directors, and the clinic, located on the same property, was under the direction of a woman's board, the two boards have merged. The clinic has become the out-patient department of the hospital, under the supervision of the hospital superintendent. A new model building has been erected and houses the out-patient department.

In 1930, five of these organizations claimed to have social service departments. In no instance did any of their social workers have social case work training or experience. The service consisted of admissions and home visits, when time per-

mitted, in addition to general clinic work, including nursing.

Now standard medical social service departments under qualified medical social workers have been established in two out-patient departments and in one unattached clinic of the health division. Two out-patient departments and the clinic connected with the religious hospital are prepared to establish such departments at this time.

The standards for a medical social service department in a clinic have been used in evaluating the work of other health agencies in the federation. Two maternity homes have secured social case workers. A sanatorium for the tuberculous is completing plans for the establishment of a standard medical social service department.

Drugs are now dispensed only by registered pharmacists, working in the clinics, on a full or part-time basis, according to the needs of the individual clinics.

Boards of directors and medical staffs have become active and are developing their work. The medical staffs have taken pride in the record systems that they have worked out in all of the clinics. Uniform reporting and statistical procedures, coinciding with those in use in the county health department and county general hospital, were recently

installed in every clinic of the federation. The council office now furnishes monthly to every federation health agency and to all members of the health committee statistical tables showing the load of each of these agencies for the month, with comparisons of the year to date with the last fiscal year. It is practically assured that Los Angeles will now be included in the areas reporting social statistics for this field to the United States Children's Bureau.

In order to secure information regarding the varying clinic admission procedures, a study was made by the committee on medical social service of new cases admitted to five clinics. The results were published in mimeographed form under the title "A Study of the Economic Condition of 250 Clinic Patients." A committee is now at work on a draft of standards for uniform clinic admission.

The sustained interest and untiring efforts of the health committee, the splendid cooperation of the lay and professional representatives of the voluntary and public hospitals and clinics, the support of the executive committee of the Council of Social Agencies, and the board of directors of the Community Welfare Federation, have made possible the progress under the "Standards for Clinics."

How High Does a Fly Fly?

Los Angeles County General Hospital started a few days of sport for the newspaper feature writers when the assistant superintendent asked the county board of supervisors to provide screens for the upper floors of the twenty-story structure.

The question "How high does a fly fly?" was discussed more or less facetiously in the papers all over the nation.

G. W. Olsen, the assistant superintendent, was placed in charge of the finishing details and furnishing of the new hospital. The windows, on unknown authority, had been screened only to the sixth floor. In seeking complete screening, the administrator had in mind not only flies but the risk of leaving windows open without screens lest rubbish or bottles be thrown out the windows and strike the open terraces below, often occupied by patients.

During the summer, Mr. Olsen relates, while the new building was being put in order to receive furniture and equipment, sticky fly paper was placed in various locations on all floors in the building. A record was kept of the number of flies caught over a period of time. More flies were caught on the upper unscreened floors, clear up to the top, than on any of the screened floors. This convinced hospital authorities that flies were entering the upper floors through the windows as well as through elevators and stairways.

The first department in the new hospital to be opened was the maternity service on the eighth floor. Nurses began to complain about flies within a few days. Improvised temporary screens had to be provided for delivery rooms and nurseries to prevent the pests from swarming there.

When the operating rooms on the fifteenth floor were opened for service, the winter season had set in and the fly nuisance had abated.

By March complaints of flies set in again, and the request for screening was renewed. The county mechanical engineer has been instructed to prepare estimates of the cost. On the basis of the original contract for screening the lower six floors, the upper fourteen floors would cost \$29,500 for 1,850 openings, bronze wire cloth set in steel frames finished with oxidized plating being used.

Ways to Clean Floors

Linoleum has a long life, is only moderately expensive and is good at absorbing sounds, according to a table on the selection and care of floors in the thirteenth edition of *The HOSPITAL YEARBOOK*.

The method of cleaning untreated linoleum suggested in the table is as follows: sweep daily with a soft brush or oil treated mop. To wash, use lukewarm solution (soft water) of mild or neutral soap. In polishing use a dry dust mop or polishing machine with fine bristle brush. Liquid or water wax emulsions are recommended for use on linoleum floors.

The table contains similar information regarding wood, cement, vitreous tile, ceramic, terrazzo, travertine, marble, rubber, cork, asphalt, plastic magnesia cement and slate as substances for flooring.



Christmas—A Matter of Spirit Not of Places



Christmas offers unequalled opportunity to make patients happy during the holiday season. Above is shown a children's ward the day after Christmas at Wesley Memorial Hospital, Chicago. There is evidence in plenty that Santa Claus has visited this group of little patients to brighten hospital days for them. Below is a little girl at Alameda County Hospital, Oakland, Calif., resting peacefully at the end of a perfect day.

A glittering Christmas tree decked with all sorts of fascinating colored lights, festoons and gorgeous balls was a breathless delight to the boys and girls at the Wisconsin Orthopedic Hospital, Madison, Wis., who assembled on the sun porch to greet Christmas. They don't seem to feel that it is a punishment to spend the day in hospital. At the right is another Alameda County Hospital patient—wreathed in smiles as well as in Christmas garlands.



What Others Are Doing

The Graduate Nurse Makes Efficient Housekeeper

The advantage of having a graduate nurse as housekeeper has been demonstrated to the complete satisfaction of Eva M. Muirhead, superintendent, Hospital of the Good Shepherd, Syracuse, N. Y. She describes her experiences in this matter as follows:

"Thoroughly dissatisfied with our own system of housekeeping and after a great deal of deliberation, I decided to try a nurse housekeeper. I finally secured one and on talking to her, her first reaction was what would be her status in the institution, should she be considered as part of the hospital staff. After being assured she would, she seemed most interested. She is one of our graduates, has held many positions of responsibility, including head nurse work, assistant in the training school, superintendent of nurses and superintendent of a hospital.

"Her intelligent handling of the situation is proving to us that she will be able to save us money inasmuch as she has made a saving in the personnel by replacing older employees with younger men and women and thereby securing more and better work. The general morale of the employees is better and higher standards of cleanliness are being maintained throughout the institution. She has also lessened the quantity of cleaning materials used by allotting to each department only a specified amount for a specified time and while this met at first with protest, it has since proved the workers are finding by lessening the amount used each day they are making their allotment do and performing as efficient work and eliminating any possibility of waste.

"She makes rounds more or less continuously and knowing that they are being checked, the employees are more alert and a better standard of cleanliness is being maintained. In her rounds she checks and reports:

"1. Leakage of radiators, which of course leads to the use of more coal and destroys floors and walls, besides being irritating to patients.

"2. Leakage in hot and cold water faucets, imperfections in toilet bowls, and the necessity of renewing washers in faucets, thus preventing large water bills.

"3. Burning of gas when not needed

in kitchen and utility rooms. Seeing that the burners are kept clean in order that the combustion may be complete; if perforations are closed or partially closed combustion is incomplete, and the oxygen in the air will not mix with the gas as it should and will deposit carbon dioxide on utensils.

"4. Turning off electric lights when not needed, thus making a saving in bill for electricity which is a big item in hospital cost.

"From her experience, a graduate nurse also has a better understanding of how a room, when vacated, should be cleaned and prepared for the reception of a new patient. She also pays more attention to details such as repairs to furniture, turning, washing or repairing window shades, thus saving replacements which would otherwise be necessary. It is within her province to make the greatest contribution to the retrenchment program because she has the handling of the personnel and the materials that are contributory to meeting the demands of a reduced budget."

New Telephone Set-Up Saves Operator's Time

Georgia Baptist Hospital, Atlanta, Ga., has recently installed an intercommunicating system in the hospital and finds it to be working most satisfactorily.

According to W. D. Barker, superintendent, the new set-up takes practically two-thirds of the work off the switchboard operator, thus giving her more time for incoming calls. Those using the extension phones can call direct to other departments in less time than it formerly took them to get the operator. The majority of the operator's work under the old system was placing calls from one station to another and locating people.

"We believe that this new system will mean good will for the hospital," says Mr. Barker, "as emergency calls come often and should be answered promptly."

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Paying for Hospital Care by Doing Repair Work

At Hillsboro Hospital, Hillsboro, Ill., the question of upkeep and repairs was a problem causing some concern. Mrs. F. I. Clotfelter, the superintendent, has shown real ingenuity in this connection in getting such work done in recent years by patients unable to pay their hospital bills, thus helping both the hospital and the patient. Many have worked out their bills by cleaning walls, painting and carpenter repair work.

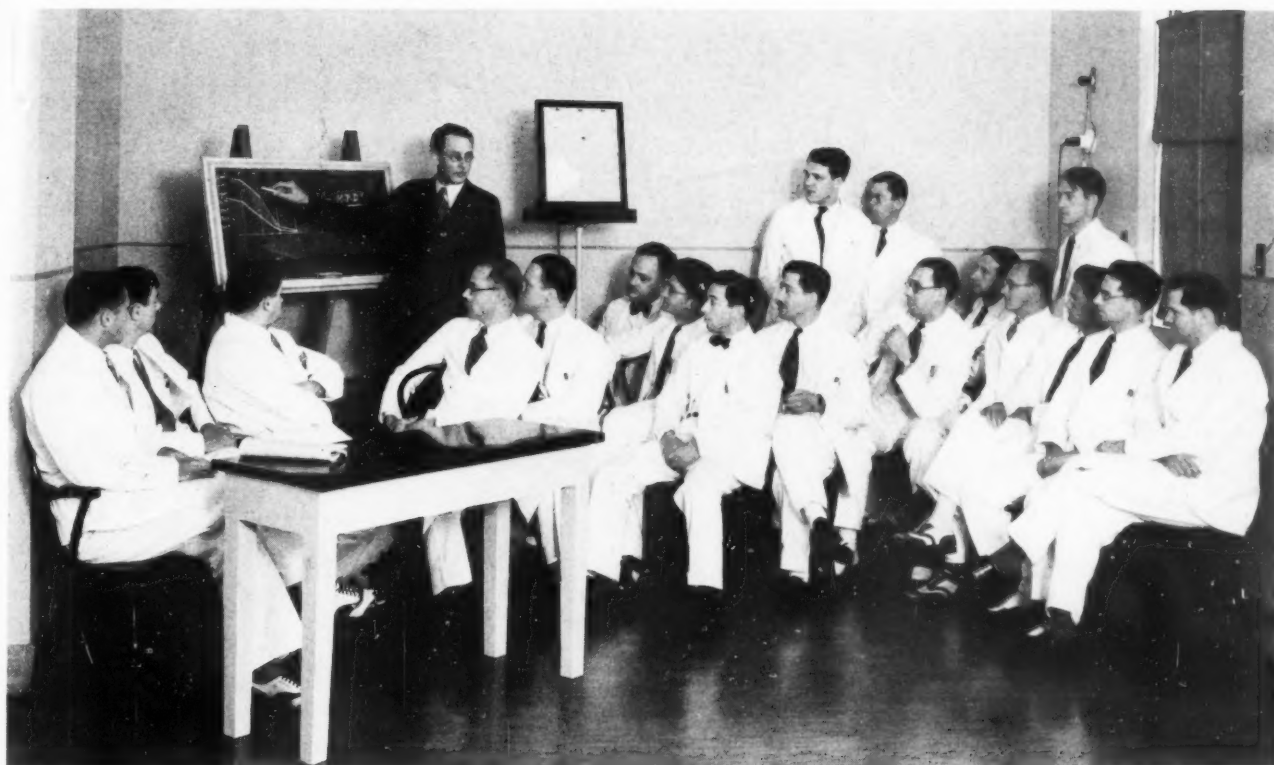
This hospital has no training school and employs mostly graduate nurses and a few undergraduates. The staff is only large enough for low occupancy and when the hospital is very busy it is able to give work to unemployed private duty nurses in the town by calling them in for floor duty. These nurses are glad to respond to such calls as private duty work is often rather scarce.

Guest Card Is Popular

Instead of the conventional gift of flowers, the patient at Toumey Hospital, Sumter, S. C., sometimes receives a guest card with this message:

Dear.....:
Your hospital charges for today have been paid by..... and we are asked to let you know that you are.....guest for the day.
The thought behind this little gift is that since you cannot be a house guest and will doubtless receive other tokens of affection while you are in hospital, your host wishes to show you the next nearest hospitality to that which it would be his pleasure to show in his own home. If this slight token gives you even the least pleasure or comfort our only other wish is for a speedy recovery.
Date.....

Charles H. Dabbs, superintendent of the hospital, reports that the guest card has proved especially popular with service clubs, fraternal organizations and other groups who wish to foster the spirit of friendship among their members.



Training the Intern

By THEODORE E. SCHWARZ, M.D.,
and OTIS WHITCOTTON, M.D.

Alameda County Hospital, Oakland, Calif.

THE very future of the art and science of medicine rests in the keeping of those who from year to year go forth to carry on the traditions of the past, the realizations of the present, and the hopes for the future of this most satisfying of professions.

Medical students who have served seven years of intensive training in the basic sciences come to the hospital willing and anxious to be taught to translate all this preparatory education into deeds of service to the sick. Accepting this product of medical schools and transforming it into good doctors constitute the creed of intern training. To have part in this development, this building of a strong character into a skilled, capable and efficient physician, is the reward and inspiration of those who take active part in an intern training program.

A report on a tried program, one that has actu-

Accepting the product of medical schools and transforming it into good doctors constitute the creed of intern training. An intern training program that has been in existence over a period of years in Alameda County, California, is described in detail by two of the staff doctors

ally been put into effect over a period of years, is of concrete value. It should be of great help to all hospitals that are confronted with the problem of intern training.

The American Medical Association designated certain teaching requirements for hospitals seeking their approval for intern training. These are minimum requirements — merely an outline of a sufficient teaching course. It would be an injustice for any institution to accept interns and give only a minimum educational program. Those who served internships many years ago remember the

haphazard manner in which training was carried out. An intern wandered through the wards without guidance, without supervision, without a planned program of service, and was obliged to pick up bits of medical knowledge wherever he could find them. The memory of those days still lingers and acts as an incentive toward making the present day training program bigger and better.

The success of a hospital training program is not due to the efforts of any one man. It is dependent upon the concentrated efforts of the entire staff, all of whom must untiringly give of their time and interest in a coordinated course of instruction. However, it must be one man's special duty to see that the staff's efforts are properly timed and smoothly meshed into a continuous program throughout the entire year.

Serves One Month in Each Department

Alameda County, California, conducts a rotating service through twelve departments, each intern serving one month in each department. Interns are not allowed to specialize and must serve in every branch of the service. After having that general experience, they will be better able to determine if they really want to specialize, and will be better prepared because of their broadened experience. A schedule of service is published, and every intern knows exactly what service he will be on in any week during the year.

The rotating service is accomplished in the various county institutions, consisting of four hospitals—an acute hospital handling about 2,000 cases a month, a chronic hospital of 750 beds, a tuberculosis sanatorium of 250 beds and a children's hospital of 180 beds.

These institutions are under the supervision and management of a medical director, and are used as school centers for the different parts of the training program.

For example, chronic medicine in all its branches is taught in the chronic hospital. This includes tuberculosis, cancer, prostatic cases, arthritis, glandular dystrophies and chest surgery, as well as reconstruction orthopedics. Patients remain for a prolonged period of hospitalization and they can be followed through a long period of convalescence. Acute medicine and surgery are taught in the acute hospital. Isolation wards are available for contagious diseases. Acute pediatric, cardiac and pneumonia cases all require intensive treatment. The same applies to surgery and orthopedics of fresh fractures.

The average patient stay is eight and a fraction days. This rapid turnover—24,000 cases a year—requires prompt examination and expedited laboratory work. The value of a smoothly func-

tioning hospital with well coordinated activities is graphically demonstrated and the intern is taught to work in harmony with other medical workers. This training is of incalculable value for his future service on some hospital staff.

The emergency department renders a splendid aid in the training of interns. One thousand accident cases every month supply an abundance of material for minor surgery, but the greatest lessons are its training in surgical judgment and experience in handling the public. Excited and grief crazed relatives will test the intern's tact and diplomacy and give him training no other department can duplicate.

The hospital has been frequently petitioned to institute a physicians' postgraduate course. These requests are invariably refused as it is felt that an institution could not efficiently conduct both schools. Either the interns' training would suffer or the postgraduate course would be insufficient. The only postgraduate work attempted is the house officers' course for men selected from the preceding year's intern group. It was decided to specialize on intern training, with all thought and effort directed toward this end in an endeavor to give the best training program possible. The course is still far from perfect, but every year sees some improvement, with constant striving for careful supervision and studied direction of the interns' activities.

Large Number of Applications Received

Applications are received from any recognized standard medical college in the United States. Ten times as many applications are received as there are positions to fill. The intern committee is composed of seven staff doctors who examine the submitted qualifications and vote for twenty-four names. Selections are then tabulated and the twenty-four applicants receiving the greatest number of votes are selected. This selection occurs on January 1, six months prior to the date of service, thus giving the chosen applicant ample time to accept or reject his appointment without inconvenience to himself or to the hospital. When the applicant accepts, he signs a contract for one year. The training course begins on July 1 and continues until the next July 1. Certificates are issued only to interns who satisfactorily finish the course. It is believed that careful selection of interns is most important, for thus is presented to the hospital staff a class of hand picked interns, constituting a group of young men who are worthy of the staff's best efforts.

The selected interns are then turned over to the committee on intern instruction. This is an important staff appointed committee that serves for one year. Members interest themselves in the co-

ordination of all lectures, demonstrations and teaching programs. They act as monitors to the teaching staff, encouraging individual staff members to greater efforts, obtaining talks by prominent visiting physicians, and seeing that the lecture program does not fail for lack of attendance.

It has been found that the staff doctor who has a son in medical college makes the best member for this work and also that certain members of the staff take special interest in matters of instruction and teaching. The staff responds to the committee's admonitions in a friendly and sportsmanlike manner and gives its whole-hearted cooperation and support.

Workaday Actualities Are Emphasized

Lectures are delivered by members of the hospital staff and by invited guest speakers. The year's schedule of lectures is prepared and published. No attempt is made to regulate the subject matter, but everyone is encouraged to speak on his own specialty and, insofar as possible, to make the talks along practical lines. For example, the orthopedic men use these periods to demonstrate the application of the various splints and fracture apparatus; the genito-urinary men teach the use of the cystoscope by allowing the intern first to practice with the instrument on an empty cardboard box. In like manner, all departments have some procedure whereby they are enabled to demonstrate and drill the intern in the manual of arms of their specialty.

It must be borne in mind that the interns come to the hospital with their minds crammed full of undigested medical knowledge as a result of four years of intensive lectures, and this is their first opportunity to put this knowledge to actual use. These lecture demonstrations transmute the college professor's orations into concrete workaday actualities.

Group consultation on individual cases is called weekly colloquia. It is a clinic in which a patient's case is presented to a jury of doctors. After the history of the case and the results of laboratory findings have been heard, the case is discussed in all its phases by a group of physicians representing a broad field of medical talent and specialization. One day a week the medical department holds such a meeting. A similar meeting is held by the surgical department. This meeting is considered better than "ward walks," as a better program is presented and more complete analysis of the case is given.

One day a week is definitely designated as the meeting of the pathologists for the presentation of postmortem material and operating room specimens. The intern who had charge of a case prepares a short summary of all the positive findings

and the progress of the case; the staff member who had charge of the patient gives his diagnosis and the scientific reasons from which he formed his conclusions; then the pathologic department presents the specimens and its report.

Thus is presented for the intern a most important and comprehensive recital of a disease in all its stages. Too much emphasis cannot be placed upon the importance of these conferences. When they are carefully planned and well carried out, many practicing physicians of the community are attracted, and their attendance helps make the conferences a greater incentive for study.

Interns are allowed to perform necropsies only under the supervision of a staff appointed pathologist. This enables them to visualize the effects of the disease and verify their bedside notes, and, with the pathologist's aid, correctly to interpret their findings. A stenographer is detailed to be present and receive the dictation covering the description of the pathology as it is encountered, as no necropsy report is accepted from memory and written days after the postmortem was performed. It is gratifying to be able to report that the percentage of necropsies to the number of deaths is 67 per cent.

Cancer clinics have been organized in order that cases of malignancy may have the benefit of group diagnosis and advice from physicians representing the various specialties. Before a case can be presented to the clinic, certain preliminary work must be done. This is the duty of an intern who sees that the case is properly prepared for presentation.

Interns Required to Attend Cancer Clinic

A case presented to the clinic is thoroughly discussed from every angle, and a final decision as to the method of treatment is the result of the discussion. Interns are required to attend every session of the cancer clinic. This is obligatory because it is felt that the clinic offers most important training and is in accord with the movement to draft the entire medical profession to make a united effort to conquer this dreaded affliction. We are in hopes of impressing our interns so that when they have completed their year's course they will go into the medical world cancer conscious and motivated with a desire to enlist themselves in the profession's mass action toward the eradication of cancer.

It was early recognized that a medical program must compete with many seductive influences in order to persuade a busy doctor to attend an evening meeting. Therefore, a program was planned for the monthly staff meetings that would be different from that of any other medical society. It was found that the hospital was able to present a large number of patients in person to illustrate any sub-

ject under discussion, even though the subject was considered to be a rare disease.

At a recent meeting when Berger's disease was the topic of the evening, all the institutions were combined and the health center records searched so that at the evening session patients exhibiting every degree of the disease's mutilations were paraded in on crutches, wheel chairs, pushcarts and self-propelled vehicles. No county medical society could stage such a display. This explains the popularity of the hospital staff meetings and accounts for the large number of visiting physicians.

This medical meeting inculcates in the intern a desire for medical association, the wish to attend medical meetings and an appreciation of the importance of an affiliation with organized medicine.

From the moment an intern enters the hospital he is considered a doctor. No trouble along lines of misconduct is ever experienced. The placing of responsibility upon the intern has proved to be of definite value, for nothing will develop a young doctor so much as carrying responsibility in proportion to his demonstrated carrying capacity. He is encouraged to make a diagnosis and to write his diagnosis in the patient's record. This develops a courage of conviction and a confidence in forming an opinion. His staff physician will either agree or disagree with the written diagnosis, but in either case will point out his reasons for arriving at this conclusion. This is splendid training.

When an intern reports on a new service, he is given individual instructions in that service and is carefully drilled and rehearsed in the department's technique. One example will suffice for illustration. Under the direct supervision of the throat special-

ist, the intern is drilled in every move and stage of tonsillectomy. He is not permitted to operate until he demonstrates a manual dexterity and an ability to do the operation in a workmanlike manner. In this same way he is initiated into each new service, receiving his instructions from a staff member.

The intern is permitted to perform only minor surgery. Though all possible responsibility is placed upon the intern, a distinct limit is put upon his field of activity. The welfare of the patient and the security of the hospital are always the first consideration. Staff physicians perform all major operations and the intern is permitted to act as the first assistant.

Six house officers are selected from the preceding year's list of interns on the basis of demonstrated ability, leadership and merit. Each house officer is in charge of a group of four interns. These men act as the intern's special demonstrators and daily instructors, correcting his errors in technique and demonstrating therapeutic measures. Recently promoted from the ranks of internship themselves, these men make relentless taskmasters. To be selected for this group is the ambition of every intern and his incentive to do better work.

The most vital factor in intern training is the attitude of the hospital staff. They are the teaching faculty, and unless their interest can be enlisted, no program can succeed. Alameda County has ninety-six doctors on its staff, representing the outstanding medical talent of the community. The appointment, for a period of one year, is renewed annually on merit. It is considered a signal honor to be elected to a position on the hospital staff.

Control Valves Save Steam

Tests were conducted recently at the University of Colorado in order to determine the savings possible in steam consumption in certain of the older buildings at the university through the installation of thermostatically controlled motorized valves on the main steam supply lines to the buildings, according to *Heating, Piping and Air Conditioning*. The following conclusions are based on the tests:

The total steam condensed during the heating season may be reduced by some form of automatic heat regulation.

The reduction increases as the ratio of the nonworking hour period to the working hour period increases.

The reduction will be less in a building equipped with a two-pipe vacuum return line system than in a building equipped with the old style Paul system.

More satisfactory temperature will be maintained by master control than with no control.

Heat loss from excessive ventilation through open windows will be reduced by zone control.

Defective design in the heating system becomes more apparent when operating with master control and the de-

fects must be remedied before satisfactory results can be obtained.

The system of heat regulation maintaining lower temperatures during the nonworking hour period will show a greater reduction in steam consumption than one that maintains the same temperature day and night.

If the nonworking hour temperature is too low, the rooms will not be comfortable at the beginning of the working hour period even though the air temperature reaches 70° F.

The controlling thermostat should be located in a room where the radiators are not regulated by hand, and where it is not affected by open windows. A corridor away from outside doors may be the best location.

The relation of night and day temperature is important and cannot be kept constant during all weather conditions. During moderate weather a night temperature of 60° F. may be satisfactory, while during extremely cold weather it would be impossible to bring the temperature up within a reasonable time in the morning. The design of the heating system and the consideration of economy will determine the proper spread between night and day temperature.

Who Is Concerned With the Reform of Nursing Education?

By SAMUEL P. CAPEN

Chancellor, University of Buffalo, Buffalo, N. Y.

NURSING is a very old occupation. It is a very new profession. It is an emerging profession, not yet fully recognized as a profession.

In order that these statements may not be misinterpreted it is pertinent to inquire what are the characteristics of a profession. Perhaps the best definition is the one proposed several years ago by Dr. Abraham Flexner. A profession, he says, involves intellectual operations with large individual responsibility; it derives its raw materials from science and learning, these materials being organized with a view to a practical and definite end; it possesses a technique which can be communicated through an orderly and highly specialized educational discipline; and, it is essentially altruistic in motivation, practiced not primarily for private gain, but primarily for the benefit of those whom the professional worker serves.

It is plain to every one who has examined the occupational activities of the nurse that nursing exhibits these characteristics. Nursing is a profession, just as teaching is a profession, although not all practitioners of either calling are equipped to carry on their respective occupations with full professional competence.

Public Recognition Comes Slowly

If a profession involves intellectual operations based on scientific materials and if it possesses a technique communicable through educational procedures, society must provide the means for prospective practitioners to acquire the requisite knowledge and skill. In the case of the long established professions the public has recognized for some years the need for effective institutions of professional education. It has supported these institutions with increasing liberality. Of late it has even become intelligently critical of them and has demanded improvement in their operations. New professions, however, and old callings which gradually rise to the professional level, generally have to wait some time before the public becomes fully

The public is vitally concerned with the quality and quantity of professional service. Hence it is concerned with professional education. It is as much concerned with nursing education as with medical education or the training of teachers. It must pay for professional education just as it pays for professional service

aware of their function in the social order and insists upon the provision of appropriate training agencies.

We are likely to forget that professional education in America through the medium of professional schools is a relatively new thing—hardly more than one hundred years old. Especially we are prone to overlook the fact that the standards of all types of professional schools were lamentably low until within the present generation. The present national establishment for professional education represents the outlay of millions of dollars and includes hundreds of thousands of students. It is one of America's most conspicuous educational achievements. But it is very new. It has been created largely within half a century. Moreover within the relatively short period of its evolution professional education has passed through several cycles.

The first was the apprenticeship cycle. Under the best conditions there probably never has been a more effective method of educating a professional practitioner than the apprenticeship method. But conditions were generally not of the best. Generally they were very bad indeed. Moreover quantitatively as well as qualitatively the apprenticeship method fell short of meeting the demands.

The second cycle might be described as the cycle of expansion. Schools sprang up to supplement apprenticeship. And because of the rapidly growing market for professional and expert services professional schools multiplied with astounding rapidity. Often they came into being without adequate provision for equipment and without any resources

whatsoever. Most of the earliest professional schools imposed no educational requirements for admission. Almost anyone who applied was accepted. These institutions commonly made a handsome profit.

Let me repeat, this is not ancient history, it is modern history. This second cycle in the development of professional education in America has not yet been run through. The older professions began, however, to leave it behind them some twenty-five or thirty years ago. There followed then the third cycle which was that of regulation and standardization. Professional and educational organizations, together with state regulating authorities, have set up standards for professional schools and have enforced general conformity to them.

Standards Should Be Defined

The cycles overlap. Professional education is still involved in the third cycle, that of standardization. But it has also entered a fourth. Standards can not be enforced unless they are first defined. Rough and tentative standards can be drawn up with little trouble. If the standards are to be precise, however, if they are to be galvanic rather than repressive, they must be based on frequent and searching study of the educational processes they are designed to regulate. The fourth cycle, the cycle upon which professional education has recently entered, I would describe as the cycle of critical analysis — analysis of professional activities, analysis of materials of instruction, analysis and often condemnation of the standards adopted.

I am struck by the fact that nursing education is passing through all four of these cycles of development at the same time, that today it is recapitulating practically the whole history of American professional education. Nursing education is still to a large extent education through apprenticeship. Schools of nursing have spread themselves across the map with a rapidity and in a volume unparalleled in the history of any other profession, and up to last year they were still spreading. The majority of these schools have been quite comparable to the schools of law and medicine of fifty or sixty years ago, lacking adequate physical equipment, adequate personnel, financial resources; making a profit even though the profit did not inure to the teachers and proprietors.

The standardization of nursing education has been going on for some years chiefly through regulation by public agencies. And now the leaders of nursing education are engaged in a critical analysis of their calling, of the type of contribution it should make to society, and of the means whereby the profession is recruited. If I am correct in my estimate of the situation, the leaders of nursing education

are in a peculiarly advantageous position to benefit by American experience in other branches.

I should like to point out what seem to me the most important conclusions to be drawn from American experience with the development of other forms of professional education and to relate them to the present status of nursing education. I invite your attention to four conclusions.

The first is that a financial investment is necessary to establish and maintain a satisfactory professional school. Most types of professional schools need money, over and above the amount paid by students in fees, not only for physical equipment but also to cover the costs of operation. The income derived from student fees may support schools training for those professions which do not involve the use of laboratories and apparatus. Such income cannot support adequately a school which prepares for one of the scientific professions. The evidence on which this conclusion is based is nationwide. Its validity is universally conceded.

It is superfluous for me to point out that this primary requirement for the establishment and maintenance of an acceptable professional school is not met by the overwhelming majority of schools of nursing. A typical school of nursing has no investment behind it. It derives no income from student fees; on the contrary its students are paid, and still the whole operation is judged to be profitable to the hospital to which the school is attached. The profit is the product of the student's work in caring for the hospital and its inmates.

Educational Factor Must Come First

Student services cost less than those of trained persons. The student's professional education is therefore nearly always in competition with the needs of the hospital. The value of the student's labor in keeping the institutional routine going takes precedence over its value to her as a means of professional education. Schools of nursing cannot be satisfactory institutions for professional education until the educational advantage to the student is the controlling factor in the assignment of her duties.

The second conclusion to be drawn from American experience in professional education is that professional schools should be conducted by trained teachers who are devoting their lives to teaching. Some types of professional schools can profit by enlisting the services of professional practitioners as part-time teachers. But it has become clear that no acceptable professional school can be managed or taught solely by persons whose primary interest and responsibility lie outside the field of teaching.

A corollary of this conclusion is that those who organize and direct the educational program should

have had special training for this function and should be given an opportunity to exercise it over a considerable period of years. The crystallization of school policy and the organization of an economical routine of operation cannot be accomplished overnight. They cannot be accomplished by a kaleidoscopic succession of supervisory officers unfamiliar with the problems involved. The development of a curriculum also is a slow process. Competent persons must spend time on the job.

Nursing Schools Have a Long Way to Go

I do not need to point out how sharply the conditions prevailing in the majority of nursing schools contrast with the conclusions which other professions have reached on these matters. In respect to both trained staff and competent continuous direction the majority of schools of nursing have a long way to go before they reach the standards now commonly in force in other types of professional schools.

The third conclusion suggested by the experience in other fields of professional training is that a reasonably high level of preliminary education is a prerequisite for successful professional study. Preliminary educational requirements for all types of professional schools have been steadily raised within the past two decades. All professional schools in other lines now require a preliminary education at least equal to high school graduation. For entrance into schools of law, medicine and dentistry at least two years of college study is required.

The State of New York makes high school graduation a prerequisite for admission to a school of nursing. But in most parts of the United States the educational standards for entrance are far below this level.

The fourth conclusion deriving from our experience in other fields is that apprenticeship methods are wasteful. In every type of professional school there has been a steady transfer of emphasis from apprenticeship methods to academic procedures. This has not always been deliberately brought about. But trained teachers find that the bodies of essential knowledge embraced by their respective specialties constantly increase, and that students learn faster and grasp the scope of the profession as a whole better by the more indirect methods of classroom and laboratory. Nevertheless, practical training, which apprenticeship gives in the most realistic way, is also essential. Where apprenticeship methods have been too completely discarded some substitute for them has to be found.

In nursing education this transfer of emphasis has only just started. The type of apprenticeship

training that still exists in nursing education is unique, and uniquely valuable. It must not be lost. In the reform of nursing education which all of us believe impends it will be incumbent upon the leaders to strike a balance between the practical and the theoretical more successfully than have their colleagues in other professions.

Who is concerned with the reform of nursing education? Teachers in schools of nursing, of course; those members of the profession occupying executive positions, of course; state educational officers, of course. But the public is also concerned. The public is vitally concerned with the quality and quantity of professional service. Hence it is concerned with professional education. It is just as much concerned with nursing education as with medical education or the training of teachers. The public must pay for professional education just as it pays for professional service. Experience has shown that it will pay as soon as it understands the necessity.

What is it that the public must be brought as fast as possible to understand? It must be made to see that there can be no assurance of adequate nursing service unless two serious situations now obtaining in the nursing profession are remedied. These situations are interconnected. They react on one another. What are they? First, there is only a handful of nursing schools in the United States that can be classed as educational institutions. And second, there is a tremendous oversupply of nurses, trained and untrained, and there is a steady annual addition to the supply far in excess of the community's needs.

Nurse Surplus Is Without Precedent

I am constrained to mention the second situation because it has a bearing on the educational program. That bearing I should like to point out to you. At different times in our history other professions have been oversupplied with members. Not so long ago there was an oversupply of doctors — some believe we are on the eve of another period of surplus in this profession. At least three times within my life there has been a serious oversupply of engineers. And one might cite other examples. But in no other calling has there ever been anything like the surplus of members which now exists in the nursing profession.

In other professional fields where an oversupply has appeared an approximate balance between supply and demand has generally been secured in the course of a few years. The balance has been restored in one of two ways. First, professional schools have raised their standards of entrance sharply. Second, students learn that the profession is overcrowded and decide not to enter it.

Why does not something like this happen in the field of nursing? Because of one very simple fact, namely, nursing schools are profitable, or are believed to be so, by the agencies that maintain them. There is no doubt about the fact that they are profitable to the students. Students in nurse training schools are the only professional students who earn their whole way while their education is in progress. If there be any who hope that the annual increment of the profession issuing from nursing schools is going to be sharply reduced by the voluntary decision of the students themselves not to enter upon training for an overcrowded profession, they are doomed to be disappointed.

What Is an Educational Institution?

I will address myself for a moment to the other situation. Regardless of oversupply it is important that more than a handful of the schools of nursing should be educational institutions. It is important that there should be no schools of nursing that are not educational institutions. What is an educational institution? I will attempt a rough definition. An educational institution is an institution whose primary objective is the progress in knowledge and skill of the students. It makes no demands on its students which tend to interfere with or retard their acquisition of knowledge and skill. It is conducted by persons qualified by training to serve as teachers and administrators. It is supported by funds adequate for the accomplishment of the ends to which it is devoted. It is not operated for profit.

The community's responsibility in this matter is plain. It is incumbent upon the community to demand adequate institutions for the professional education of nurses, an adequate number of institutions, institutions adequate in human and material facilities; and to see that they are supported. The community has a responsibility likewise to replace as soon as possible all institutions which depend upon the labor of students for the economical conduct of another enterprise which is not educational.

In making this statement I do not mean to reflect on the motive of hospitals in establishing and maintaining training schools. In the majority of instances the motives have undoubtedly been of the highest. Under the present system great progress has been made not only in hospital efficiency, but also — and in spite of all obstacles — in nursing education. But the system is now seen to be obsolete. It must be superseded as soon as practicable.

How is the community's responsibility to be brought home to it? It seems to me that three groups of persons are under obligation to act as

interpreters. Three groups of persons must collaborate in making plain to the community the need for appropriate nursing education and the course that reform must take. These are: the nursing profession itself; hospital authorities, both board members and executives, and the officers of universities.

The profession has already done its part. The voice of the profession has cried aloud for many years. At first it cried in the wilderness and none would listen. But the profession refused to be discouraged. At its instance during the last two decades studies have been made and published which revealed the fundamental weaknesses of the provisions for nursing education. The last of these studies, that of the Committee on the Grading of Nursing Schools, was in a large measure financed by the voluntary contributions of the nurses themselves. Equally self-sacrificing devotion to a great public cause has perhaps never been shown by any other profession. At least I know of no parallel example. Indeed, the nurses have done their part.

But the hospital authorities and the universities have not yet fulfilled their obligations. It is now their turn. Hospital authorities have something to lose and a great deal to gain by reform. I do not minimize the difficulties. I know that reform can not be effected suddenly, however much hospital authorities may judge it to be desirable. But I venture the assertion that no board member or superintendent of a hospital which conducts a nursing school has any right to accept the present situation complacently. No board member or superintendent dare to be satisfied until the school for which he is responsible is either converted into a genuine educational institution with whatever it may need of additional financial resources and educational affiliations, or is discontinued.

Universities Must Also Cooperate

The obligation resting upon the universities is scarcely lighter. Universities are the principal agencies maintained by society to conduct professional education. It is the function of universities not only to offer the types of professional education already well established, but also to be alert to the educational requirements of new professions and to organize new kinds of professional training as soon as the need becomes manifest. Thus far the majority of universities have been peculiarly blind to the problems of schools of nursing. But their future rôle is clearly defined. They must both interpret these problems to the world, and bear a hand in the study and further development of nursing education.¹

¹Read at the meeting of the New York State Nurses' Association, Buffalo, N. Y., October 17, 1934.



Occupational therapy department, University of Chicago Clinics.

Acute Patients, Too, Will Benefit by Occupational Therapy

OCCUPATIONAL therapy, devised to meet the needs of disabled soldiers, first came into prominence in that difficult period immediately following the World War.

We are once again going through a world crisis and the human wrecks it is leaving in its wake are challenging the best minds to invent ways of meeting their needs. It seems to me that the present crisis, which in some ways has been as devastating as the World War, should logically produce the second great stimulus to occupational therapy, particularly in the general hospital.

The general hospital of 1934 is a very different institution from the hospital of 1900 or even that of 1920. Let us consider some of the more pertinent trends, together with their significance for occupational therapy.

A high degree of specialization has obtained in

By PAUL KELLER, M.D.

Executive Director, Newark Beth Israel Hospital,
Newark, N. J.

The economic crisis, like the World War, is leaving human wrecks in its wake. Doctor Keller believes that occupational therapy is the solution for these persons who must be restored to economic usefulness, and he urges the general acute hospital to make provision for such a department

the field of medical practice within the past few decades, and the hospital patient has become little more than the sum total of a number of different physiologic systems, the particular systems that characterized any given individual depending entirely on the location of his complaint. The patient as a personality did not exist.

Within our time, however, there has gradually developed a realization that the patient as a personality is to be reckoned with, that he can advance or impede the work of the physician, that he can materially help or retard his own recovery, that he can be either a functioning, cooperative individual or just an inanimate receptacle for medication. In short, the physician is learning to regard the patient as a partner in his own cure and to realize the importance of securing his interest and assistance in the treatment processes.

New Surroundings Bewilder Patient

Just to approach the patient with a pleasant bedside manner is not sufficient to win him over. Removed from his normal way of life, placed in a strange building, in a strange bed, in a strange room, among strange people, and under a strange routine, the patient becomes bewildered. Deprived of his usual activity, he loses all sense of time and is likely to spend far too many hours on unhealthy introspection. The result is discouragement, depression, feelings of inferiority and inadequacy, and mental sluggishness.

Here is an opportunity for the occupational therapist who is alert to the possibilities of her job aside from its purely therapeutic function. If she can get the patient to attempt some simple activity, she can gradually catch his interest and awaken his enthusiasm. A patient whose hands are kept busy will have his mind occupied. If he can work for only a few moments at a time, he develops a new lease on life and a new interest in getting well. The experience of creating something with his own hands gives him a new valuation of his own worth. Except for the limitations imposed by his physical condition, he thus retains, as far as possible, his usual mental habits, attitudes and outlook.

Here is another task for the therapist. If she is to win over the patient, she must have as her ally the attending physician. She must win his confidence and his cooperation. For the most part, the medical staffs in general hospitals know little of the value of occupational therapy, and the average physician, through his inexperience with this field, has relatively little interest in the subject. However, it is certain that if occupational therapy is to have any significance in the general hospital, it must win and hold the respect and the cooperation of the medical practitioner. He must be willing to

assume an important rôle. He must be urged to see the necessity of requesting occupational activity for his patient on a prescription basis and of insisting on a high standard of clinical recording and progress notes. Thus, occupational therapy comes to the patient at the order of his doctor, but it is the therapist herself who must, at first at least, call the doctor's attention to the need, hold his interest through consultations and conferences, and finally secure his whole-hearted participation through reviews of successful results.

But even before the hospital physician comes the hospital administrator. He, too, is, for the most part, uninformed of the place of occupational therapy in the hospital scheme. Exceptions, of course, are administrators of institutions for the mentally sick who have long since recognized this work as an important factor in the treatment of mental patients. In New Jersey, for instance, the large public hospitals for mental and nervous diseases, both state and county, have highly developed departments of occupational therapy and have in many instances erected special buildings for this purpose. The small private sanatoriums have their therapists. Public institutions for the treatment of the tuberculous, where the need is equally obvious, likewise make occupational therapy a major part of their programs. But not so the general acute hospitals.

If we were to approach the average hospital administrator today with a request for an occupational therapy department, his immediate response would be, "Not now. The depression has put an end to hospital frills. Our money must be conserved for essentials." I refuse to classify occupational therapy as a hospital frill, and I maintain that just because of the depression, just because there is a shortage of funds, the administrator should be more than ever interested in instituting such a department.

An Enthusiastic Publicity Agent

One of the most serious concerns of the administrator today is that of publicity. Some institutions are employing public relations men at good salaries, some are developing carefully thought out radio programs, while others are trying through personal contact to make their value known to the press.

This trend has great significance. General hospital administrators are frankly making a bid for public favor. Where could they hope to find a more enthusiastic publicity agent than the satisfied, contented patient? What patient will not tell his friends and neighbors of happy hours spent in the hospital workshop, creating out of colorful materials some bit of attractive handwork? What pa-

tient will fail to advise his friends to go to a certain hospital because there they can have some bedside occupation to help while away the weary days! The happy patient is as powerful and inexpensive a form of hospital publicity as can be found, a fact that the administrator cannot afford to overlook.

It is argued that occupational therapy, by facilitating recovery, reduces the number of hospital days per patient. I do not recall having seen any figures on it, but it seems to me that if occupational therapists as a professional group could make a comparative study of the average length of hospital stay in two institutions that were similar from every other standpoint, and could discover an existing relationship between occupational therapy and the number of hospital days per patient, they would have a most powerful tool with which to work. No executive would label any service a frill if it reduced the cost per patient and released beds for greater service to the community.

Making Patients Economically Useful

There is still another aspect of this whole problem that probably has more far-reaching implications than any yet discussed, and that involves the entire relationship between the hospital and the community. What does the hospital expect of the community, and what does the community expect of the hospital? If we glance at the historical development of the hospital, we find a series of changes in its social relationships. There was the early seclusive institution that accepted the undesirables of society for custodial or domiciliary purposes. Then came the more scientific hospital that took in the acutely sick in order to cure them but had no concern for their health after they passed through the hospital door. Then we find the modern, more socialized organization that not only cures, but also takes steps to assure, insofar as possible, the permanency of that cure. And finally, there is the most progressive type of hospital that assumes as its further concern the prevention of disease, the promotion of health and the general welfare of its patients.

This modern type of hospital has a definite community relationship. It assumes a responsibility for the health of its residents, and by health is meant not the mere absence of disease, but that state of well-being that enables an individual to function normally in his usual environment.

We live in a civilization in which the major emphasis is centered around matters of economic concern — the business of making a living. It thus becomes the goal of the hospital to restore its patients to that state of health or well-being that will enable them to become economically useful. To be economically useful means, in its simplest

terms, to be able to work, whether at an outside job with a weekly pay envelope or at a housewife's duties with or without a small spending allowance.

What about those patients who, through illness, have lost this ability to work? Are they not part of our responsibility? Let me give you an illustration. Mr. X comes to our clinic. He is a tailor by trade, never earned much, managed to maintain his family on a minimum basis, but has never been able to accumulate any savings. The doctors tell him he has an overactive thyroid that is seriously affecting his general condition, and if he does not take care of it now, through rest and surgery, he will develop complications and permanently impair his health.

"But how can I afford to give up my job?" he asks. "There is no one to support my family."

We help him get a long time view of his condition and he consents to our plan. He gives up his job, comes into the hospital for a period of observation and rest, submits to surgery and finally settles down to a long, stormy convalescence. In the meantime, he has placed his family on public subsidy, at our instigation and with our help. At first he is uncomfortable about it, but later he settles down in serene complacency in the knowledge that someone is carrying his burdens. Prevented through illness from meeting his responsibilities as head of his household, he begins to feel inferior and inadequate, but soon finds compensation in the fact that, after all, it is not his fault; it is because he is a sick man. And so he develops a new mental habit. Now he finds comfort in being ill; it is a way of escape.

What Is the Solution to the Problem?

Eventually we tell him he may try to do some work. At the mere mention of it his pulse quickens, his temperature rises, his heart begins to fibrillate and he breaks out in a heavy perspiration. Even his hands begin to shake. He couldn't think of working. For he knows intuitively that as soon as he is pronounced fit to work, his relief will be cut off. Are we to close our story here? Is it fair for us to leave him at this point? Do we, who encouraged the man in the first place to learn habits of dependency, feel no responsibility in helping him to learn habits of work? Do we have a feeling of a job carried through to completion, a job well done?

The story of Mr. X can be duplicated a hundred times in any hospital with many variations. What is the solution to this problem?

It seems to me that the answer lies in the occupational therapy field — that there is a definite need for occupational therapy as a regular activity of the out-patient department. Attractive occupa-

tion, carefully selected according to the patient's physical and emotional needs, prescribed by a physician, supervised by a therapist, and housed in the protective atmosphere of a medical institution, free from the demands and competition of the industrial world, will soon reduce the bills for bromides. The patient will be gradually restrained to his former work habits. Little by little, he will regain confidence in himself, pride in the work he creates and a feeling of satisfaction in his own strength and usefulness. If at all possible, he should be given some pay for the work he does, either from the sale of the articles or in the form of a weekly pay envelope since this will serve to hasten his progress.

This brings me back to the point I made at the beginning, namely, that the economic crisis of the past few years should provide a tremendous stimulus and impetus for further growth of occupational therapy. Large blocks of our population have been living under continuous stress and strain for several years. Economic insecurity has been accompanied by constant fear and apprehension. For many, there has been a definite weakening in the emotional fabric. From widely separated parts of the country there come reports that much of the clinic load is emotional rather than physical. Clinics are carrying large numbers of psychoneurotics, patients with anxiety neuroses and gastric neuroses, and others who for one reason or another have been accustomed to long dependency, all seeking refuge in the manifestations of diseases which they do not have.

When we add to these the usual cardiac, thyroid and long time orthopedic conditions, we find a considerable portion of the clinic load eligible for the workshop, whether it be for physical correction, emotional adjustment or both. The clinic

workshop should be, as I see it, not for those patients who are so handicapped as to require sheltered employment permanently but primarily for those patients who must relearn how to work, or, in other words, for those who, through a period of industrial convalescence, can be nursed back to economic usefulness.

This is a difficult program. In order to be successful, it must be accompanied by administrative safeguards. Occupational therapy should be an integral part of the hospital set-up as are x-ray, laboratory, dietary and other departments. Its growth should come from within rather than from without. The department that is established and supported entirely as the project of an outside organization is not likely to develop the same degree of effectiveness and professionalism that is demanded of other hospital departments.

Occupational therapy should be under the direction of a well trained, highly qualified and competent person who has a fine understanding of the relation of her work to that of other departments in the institution and who can effect good working relationships. Particularly important are the relationships with the nurse who administers the bedside care and manages the patient in the clinic and with the social worker who studies his occupational history, evaluates his emotional needs, knows his economic requirements and helps him plan for the future. There must be joint thinking, joint planning and joint working.

It is likewise important that the director be a good pioneer, one who can carry on a continuous publicity campaign, one who will seize every opportunity to inform the hospital personnel about her work.¹

¹Adapted from a paper read at the Tri-State Occupational Therapy Association, Philadelphia.

Beauty Shop Helps Patients

Patients in mental hospitals derive a great deal of benefit from a beauty shop connected with the institution, in the opinion of Ardys Larson, Hospital for Mental Diseases, Milwaukee, who delivered an interesting paper on this subject at the seventeenth annual meeting of the American Occupational Therapy Association. She said in part:

"The establishment of a beauty shop at our hospital for the care and treatment of patients was authorized in 1928. It is part of the occupational therapy department and is under the supervision of the medical staff.

"The work consists of simple beauty operations — hair cutting, curling, finger waving, shampooing, manicuring and facial massage. Anything as intricate as permanent waving or hair dyeing is not attempted.

"Each ward has its day at the shop and patients are allowed to have attention once a week. Last year our treat-

ments totalled 5,565. One might think that this would prove expensive to the hospital, but we have computed that during the past year the cost of each treatment, in its entirety, is approximately three cents. We have two or three of the better patients trained to assist with the work. They do very well and enjoy having a pleasant occupation and a little responsibility.

"The reaction of the patients to this treatment has been both interesting and satisfying. The restless cases are more calm after they have been groomed. The depressed, who come in with heads bowed in a dejected manner, straighten up a bit and sometimes without urging will smile at their reflections in a mirror.

"The effects of treatment are, perhaps, most noticeable in the hyperactive and noisy cases, such as maniacs. A facial massage will usually quiet them and prove restful and relaxing. We have patients from the violent ward every week; they are our most enthusiastic clients."

A Simplified Accounting System for a Small Institution

By M. POLLAK, M.D.

Medical Director and Superintendent, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.

SMALL institutions with limited personnel are as greatly in need of a proper accounting system by which expenditures can be checked as are large ones with a more adequate number of experts on their administrative staffs. In fact, because the funds of the former are usually painfully limited, the pennies wasted may have a more disastrous effect.

Every hospital accounting system has the following twofold objective: (1) to give a clear view to the proper authorities as to how the money of the institution is spent and (2) to provide the hospital executive with means for checking the expenditures of the various departments and for determining whether or not the services of the institution are rendered on an economical basis.

Since accounting has nothing to do directly with the welfare of the patient, it is of primary importance that the cost of an accounting system shall not be prohibitive. It is obvious that a system designed for the control of economy cannot be in itself too expensive.

During the last four years there has been established in our institution an accounting system, the practical workings of which I shall endeavor to describe.

How the System Actually Works

Peoria Municipal Tuberculosis Sanitarium has ninety-three beds. Its administrative personnel consists of the medical superintendent who is also medical director, a storekeeper, a secretary and a superintendent of nurses. Since the chief concern of the director is the medical care of the patients it is natural that the time he spends on administrative affairs is limited. The duties of the superintendent of nurses and of the secretary are also diversified. They, too, can spend only a limited time with business affairs. Yet, even under these conditions, the business management is carried on, we believe, in an efficient way.

Let us see how this system works in practice. First we shall consider order, delivery and issue. The storekeeper issues all supplies, places the orders for the goods after they have been approved

Small institutions with limited funds must watch their pennies. Doctor Pollak here describes the bookkeeping procedures and record systems by which he controls the purchase and issuance of supplies. The system of bookkeeping evolved by the American Hospital Association has been adopted in this institution

by the superintendent and keeps the supply books. Every order, even when given by telephone, has to be entered in the order book and signed by the superintendent.

Goods are delivered only at stated hours during the morning. Deliveries are received and checked by the storekeeper as to quantity and quality against a delivery slip or invoice. The invoices are later checked again in the office by the storekeeper as to unit price and total charges, and entries are made in the supply book.

The supply book consists of loose leaves and has a separate ledger for each item as, for instance, roast beef, pork chops and chicken. Each sheet has the following columns: date, name of vendor, unit price, quantity purchased, total amount of quantity purchased during the month, quantity issued, total amount of quantity issued during the month and amount on hand.

Each morning the invoices received in duplicate during the previous day are placed on the superintendent's desk for his scrutiny and signature and for allocation to the different departments, as kitchen or medical supplies. Then they are entered by the secretary in a journal in which every purchase is recorded in chronological order.

SCHEDULE A				
PEORIA MUNICIPAL TUBERCULOSIS SANITARIUM				
July, 1934				
Total Hospital Days in July, 1934				2,819
Total Hospital Days for Year, 1934				19,571
COST OF OPERATION				
July, 1934				
		Per Capita	Per Day	
Operating Expense Disbursements (Schedule B)	\$5,302.61	\$1.8810		
Add Deferred Expense Charges (and Accounts Payable)	543.67	.1929		
Subtotals	\$5,846.28	\$2.0739		
Add Depreciation	979.39	.3474		
Operating Cost for July	\$6,825.67	\$2.4213		
COST OF OPERATION				
Year 1934				
	1934	Per Capita	Per Day	1933 Under
		Per Day	Per Day	Per Capita
Operating Expenses	\$42,199.55	\$2.1562	\$2.1889	\$0.0327
Add Depreciation	6,855.73	.3503	.3728	.0225
Operating Cost Year 1934 to July 31	\$49,055.28	\$2.5065	\$2.5617	\$0.0552
MEAL COSTS				
	For July	Totals for Year		
Meals Served to Patients	8,457	58,713		
Meals Served to Employees	3,455	23,104		
Subtotals	11,912	81,817		
	Total	Per Capita	Per Day	
Raw Food Cost (Schedule B-2)	\$1,731.07	\$0.4360		
Kitchen and Dining Room Expense (Schedule B-2)	486.29	.1224		
Subtotals	\$2,217.36	\$0.5584		
Depreciation on Equipment	77.69	.0196		
TOTALS FOR JULY, 1934	\$2,295.05	\$0.5780		
MEAL COSTS				
Year 1934				
	1934 Cost	1933 Cost	1934 Under	
	Totals	Per Capita	Per Day	1933 Cost
Raw Food Cost	\$11,771.03	\$0.4316	\$0.4368	\$0.0052
Kitchen and Dining Room Expense	2,955.16	.1084	.1039	.0045
Subtotals	\$14,726.19	\$0.5400	\$0.5407	\$0.0007
Depreciation on Equipment	543.83	.0199	.0197	.0002
TOTALS, YEAR 1934 to July 31	\$15,270.02	\$0.5599	\$0.5604	\$0.0005

Fig. 1.

Every supply is requisitioned from the storekeeper and issued by him at stated hours in the morning, and every issue is entered daily in the supply book.

Next we shall consider accounting as it applies to linen. The institution has no laundry and the washing is done by a commercial house. A close watch over this item is, therefore, doubly important. The linen room is in charge of a seamstress who is employed for three days a week. Soiled linen is sent out three times a week and clean laundry is received at the same time.

Soiled linen, collected in hampers on the various divisions, is counted by the seamstress in the presence of the laundry driver and a slip in duplicate is made out by her of the linen of each division. The original slip is sent with the bundles and the duplicate is retained in the linen room.

The laundry is obliged to make a count as soon as the bundles are received and immediately call the superintendent of nurses whenever a discrepancy in the counts is discovered. Such discrepan-

cies are then immediately corrected on the duplicate slip retained in the linen room. Clean laundry is delivered with the original slips and these are checked against the duplicates.

Laundry to the divisions is issued three times a week on laundry days on requisitions made out by the charge nurses. These requisitions have to be presented at first to the superintendent of nurses who checks on the needs and signs her approval. The seamstress, having honored the requisitions, makes the entries in the linen book.

This book has loose leaves and every item—pillowcases, sheets and counterpanes—has a separate ledger. These ledgers are arranged in the same sequence as that in which items are printed on the laundry slips.

Each ledger has the following columns: date, quantity on hand, amount incoming from the laundry, total amount on hand, a separate column for each division to which linen is given out, total amount issued, and amount remaining in the linen room. The headings of these columns are self-explanatory.

At the end of each month the figures of each col-

SCHEDULE B				
PEORIA MUNICIPAL TUBERCULOSIS SANITARIUM				
CASH ACCOUNT				
July, 1934				
July 1, 1934—Balance on Hand (after paying June bills)				\$11,709.55
RECEIPTS				
From Patients—Laboratory	\$ 8.00			
—X-Ray	37.50	\$45.50		
Produce From Farm		30.81		
Donation		3.00		79.31
(Refunds collected in July, amounting to \$43.69 are deducted from Accounts.)				
TOTAL FOR WHICH TO ACCOUNT				\$11,788.86
DISBURSEMENTS				
OPERATING EXPENSES				
Medical Treatment (Schedule B-1)	\$1,775.71			
Food (Schedule B-2)	1,731.07			
Other Kitchen and Dining Room Expense (Schedule B-2)	414.32			
Occupancy Expense (Schedule B-4)	685.28			
Other Operating Expense (Schedule B-4)	486.69			
Administrative Expense (Schedule B-5)	213.24			
TOTAL OPERATING EXPENSES				
PAID	\$5,306.31			
Less Discount Taken	3.70			
NET OPERATING EXPENSES				
PAID	\$5,302.61			
FOR DEFERRED EXPENSE ITEMS				
Insurance	\$ 0.00			
Other Sanatorium Expense	380.14	380.14		
ACCOUNTS PAYABLE			159.16	
CAPITAL ASSET DISBURSEMENTS				
Land	\$700.00			
Land Improvements	102.99			
Structures	8.00			
Office Equipment	101.25			
Hospital Equipment	3.25			
Kitchen Equipment	10.28			
X-Ray Equipment	190.61			
Water System	49.50	1,165.88		
TOTAL DISBURSEMENTS FOR SANATORIUM PURPOSES		\$7,007.79		
OTHER ITEMS				
Clinic Expense (Schedule B-6)	\$222.63			
Farm Expense (Schedule B-7)	70.85	293.48		
TOTAL DISBURSEMENTS			7,301.27	
BALANCE—After paying July bills				\$4,487.59

Fig. 2.

umn, except those headed "on hand" and "remaining," are added, and in this way the respective turnovers during the month are ascertained and recorded. Discards and new additions are recorded in the linen inventory.

Now let us consider monthly statements and bookkeeping. At the beginning of each month, statements are rendered by vendors of purchases made during the previous month. These statements are checked by the secretary against the previously received invoices and any errors corrected.

In order to take advantage of cash discounts, when due, not later than the eighth of each month, the statements attached to the respective invoices are placed on the superintendent's desk for scrutiny and signature. The statements with the original invoices are then sent to the city comptroller who makes out the vouchers, secures the necessary signatures for them and mails out the checks. The duplicate invoices are kept in the business office.

We gave much consideration to the question of whether we should employ our own expert bookkeeper or have the bookkeeping done by an accounting firm. We found that the salary of a bookkeeper would be prohibitive considering our limited means and, furthermore, that the actual time spent in bookkeeping would be a matter of only a day or two. It was decided, therefore, to have the bookkeeping done by a firm of certified public

OCCUPANCY EXPENSE							
	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY
Fuel	330.26	418.46	343.21	327.25	52.86	42.65	
Labor	505.37	503.27	485.52	475.97	479.04	486.74	
Electricity	149.80	137.50	122.50	130.50	121.50	151.00	
Janitor Supplies	33.57	39.13	24.61	251.14	23.79	25.00	
House Supplies	32.18	25.74	42.97	52.46	66.70	75.23	
Building Repairs	169.07	173.94	170.34	161.44	170.05	158.78	
Equipment Repairs	35.61	39.23	19.43	50.56	3.99	3.84	
Maintenance of Grounds	3.57	13.07	50.65	60.64	36.50	41.67	
Insurance	34.88	34.88	34.15	31.53	31.20	30.48	
Maintenance of Sewage Plant	20.20	14.42	14.42	4.75	12.79	4.06	
Total	1314.51	1389.60	1307.80	1226.06	985.52	1021.63	
OTHER OPERATING EXPENSES							
Water Expense	11.71	6.02	6.02	10.25	7.75	13.92	
Laundry	398.89	478.36	432.32	461.80	474.08	584.05	
Auto Repairs	52.98	43.88	32.51	37.06	29.99	33.82	
Auto Expense	34.29	33.68	38.02	31.18	33.84	30.29	
Auto Insurance	3.78	3.78	3.78	3.70	3.40	3.40	
Library	0.62	0.62	0.62	0.62	0.62	0.62	
Total	508.27	466.35	513.27	544.62	549.63	660.15	

Fig. 4.

accountants whose fee of \$440 a year, in monthly installments, is within our means. This fee, however, does not cover the total cost of the hospital's accounting system.

These accountants call on the eleventh of each month at the city comptroller's office and receive from him our invoices and statements. From these the proper entries are made and the statements and invoices are returned to the city comptroller for safe keeping.

For our bookkeeping system we have adopted the system evolved by the American Hospital Association. Following this system itemized entries are made according to the different hospital departments, as medical treatment and kitchen.

From the books a condensed monthly financial statement is made out. This statement deals with the following headings: cost of operations, per diem cost, cost of food, meal costs per day, money received during the month, disbursements detailed, money in the hands of the city treasurer after paying monthly bills, estimated income for the remainder of the year, itemized exhibits for the different departments and a summarized exhibit according to the different departments (Figs. 1, 2 and 3). Opposite each item exhibited we find the following columns: paid in cash, from deferred expense account, totals for month, totals for year, total budgets for the past months of the year, and under and over budget.

This statement is made out in adequate number of copies, the original to be retained in the business office of the sanatorium, and copies to be distributed to each board member and the mayor.

SPRINTS MUNICIPAL TUBERCULOSIS SANITARIUM						
EXPENSE ANALYSIS						
July, 1934						
	Paid in Cash	From Deferred Exp'ts.	Totals for Month	Totals for Year	Reven. No. Budget	Under Over Budget
SCHEDULE B-1						
MEDICAL TREATMENT						
Physicians and Surgeons	\$536.67		\$536.67	\$3,971.66	\$4,200.00	\$228.34
Nurses	844.41		844.41	5,957.85	5,950.00	7.85
Occupational Therapy	30.00		30.00	210.00	210.00	0.00
Children's Supervisory	77.20		77.20	681.44	758.33	76.89
Drugs	92.75	\$ 5.63	98.38	814.70	875.00	60.30
Supplies	8.30	36.70	45.00	337.55	383.33	45.78
X-ray Expense	61.36	5.16	66.50	647.87	583.33	64.54
Laboratory Expense	34.74	25.37	60.11	411.97	525.00	113.03
Miscellaneous	35.00		35.00	407.05	420.00	12.95
Surgical Supplies	35.22	0.48	35.70	290.90	233.34	57.56
TOTALS -	\$1,775.71	\$27.14	\$1,802.85	\$13,570.99	\$14,336.33	\$765.34
SCHEDULE B-2						
FOOD						
OTHER KITCHEN AND DINING ROOM EXPENSE						
Labor	\$370.45		\$370.45	\$2,362.47	\$2,333.33	\$29.14
Fuel	17.78		17.78	127.49	145.83	18.34
Supplies	9.69	\$62.04	71.73	605.43	350.00	255.43
Repairs	6.40	7.93	14.33	59.77	116.67	56.90
TOTALS -	\$414.32	\$71.97	\$486.29	\$2,955.16	\$2,945.83	\$9.33
SCHEDULE B-3						
OCCUPANCY EXPENSE						
Fuel	\$ 25.89		\$ 25.89	\$1,444.60	\$1,750.00	\$305.40
Labor (Janitors, Housekeepers, et al)	452.96	\$27.04	480.00	3,112.85	3,325.00	212.15
Electricity	136.60		136.60	949.30	977.50	28.20
Janitor Supplies	1.95	17.12	19.07	186.30	291.67	105.37
House Supplies	26.78	22.34	49.12	381.79	291.67	89.12
Building Repairs	10.04	118.59	128.63	1,132.27	1,166.66	34.39
Equipment Repairs	0.00	3.84	3.84	156.49	525.00	368.51
Maintenance of Grounds	26.06	11.37	37.43	211.23	525.00	313.77
Insurance	0.00	30.74	30.74	227.84	262.50	34.66
Maintenance of Sewage Plant	0.00	4.04	4.04	74.72	87.50	12.78
TOTALS -	\$685.28	\$225.06	\$910.34	\$6,142.99	\$7,222.50	\$1,079.51
SCHEDULE B-4						
OTHER OPERATING EXPENSES						
Water Expense	\$ 0.00		\$ 0.00	\$ 55.47	\$ 87.50	\$ 32.03
Laundry	461.05	\$ 0.71	461.76	2,991.39	2,625.00	366.39
Auto Repairs	5.25	35.04	40.29	270.73	175.00	95.73
Auto Expense	20.39		20.39	221.69	228.58	6.89
Auto Insurance	0.00	3.40	3.40	25.24	29.17	3.93
Library	0.00	0.62	0.62	4.37	17.50	13.13
TOTALS -	\$486.69	\$39.97	\$526.66	\$3,569.00	\$3,158.75	\$410.25

Fig. 3.

From the monthly financial statement, the secretary makes entries in the book of monthly comparisons (Fig. 4). From this the itemized expenditures can be compared individually from month to month and every excess can be easily recognized and checked. Should an excess be detected the supply book is consulted to find which particular goods were purchased or issued in excess during the month.

For the practice of economy in hospital expenditures, an adequate accounting system is indispensable. The cost of such an accounting system must be reasonable; otherwise it defeats its purpose.

The accounting system must give clear information separately of every department and individually of its subdivisions. In order that the necessary information may be at hand at any time without

further figuring, the system must be conducted in the manner of a perpetual inventory.

The system described here is clear, concise, gives all information needed for the proper control of expenditures, and its cost is so reasonable that even the smallest institution can well afford it.

Sanatoriums should conduct their accounting under a standardized system, so that the expenditures of the different institutions may be easily compared. Institutions organized not for profit have no better way to determine whether or not they are conducted on an economical basis than by comparing their expenditures with those of similar institutions. For this purpose, however, figures must be comparable, and this cannot be accomplished unless accounting systems are comparable. The accounting system adopted by the American Hospital Association can profitably be adapted.

What Kind of Publicity?

By LUCIUS R. WILSON, M.D.

Superintendent, John Sealy Hospital, Galveston, Tex.

IN THE last few years hospital publicity has been widely discussed, but many of these discussions cover only the types of publicity which I feel are of doubtful value.

Hospital publicity is of course essential, but I have never been able to take any part in the type so often used. For instance, a paid advertisement with exaggerated statements in a local newspaper to me is repulsive. Newspaper stories concerning commonplace items such as the removal of a foreign body from the lung, conveying a patient to a hospital in an airplane or the treatment of some unusual condition have never appealed to me. Talks at luncheons or before civic clubs in which the speaker attempts to work on the emotions of his audience by describing pitiful cases, usually sick children, incline toward the morbid side of hospital work, and I feel should be avoided. I doubt if patients or their families appreciate having their illness publicly discussed. Certainly their misfortunes are private affairs, and no one should feel at liberty to discuss them in public.

The Wrong Method

Publicity of these types has so often been urged on hospitals that I have wondered what was wrong with me that I could not undertake such a program. On many occasions I have resolved to do so but could never break down the barrier of my

feelings, neither could I definitely tell of what that barrier consisted. Only recently was an explanation offered that satisfied me.

None of the mentioned methods is distinctive. Any hospital of recognized standing should in the course of a few months render such service in its daily routine. Such items are so commonplace that to tell of them publicly seems to me to be a sign of weakness in hospital development rather than an indication that an institution is carrying on work that is especially noteworthy.

The Right Method

The kind of publicity that is worth while deals with distinguished service. When a hospital really has developed a distinguished service in the sense in which this term is used in an article in the September issue of *THE MODERN HOSPITAL*, a favorable impression will be made upon the citizens without resorting to any of the questionable methods now so commonly used in placing the hospital before the eyes of the public.

Most certainly distinguished service is what all of us should strive for. If we should spend the time along these lines that is now spent in telling about ordinary hospital procedures as though they were extraordinary, I believe progress and support would come in a quiet, dignified but truly effective manner.

How Hospital Insurance Problems Can Be Minimized

By RUTH M. THORPE

Superintendent, Golden State Hospital, Los Angeles

INSURANCE protection has become a paramount essential in modern civilization. The trend of the public mind in this direction has added many perplexing problems for daily consideration of hospitals.

Hospital insurance problems may be divided into two general classifications. First are those problems that deal with insurance protection of hospitals against the hazards of fire, malpractice and public liability claims for accidents that occur in hospitals. The second classification of insurance problems pertains to the payment of treatment rendered the so-called insurance patients. This paper deals with the second and more perplexing group. Almost daily patients present themselves, or are brought to hospitals by other persons, alleging that someone other than the patients themselves will pay for or be responsible for the payment of hospital and medical service.

If the admitting officer or superintendent has a reasonable knowledge of insurance coverage, it is not difficult for him to classify the request for service into one of five insurance classifications—workmen's compensation, public liability insurance, personal health and accident policy, hospital benefit contracts and miscellaneous insurance.

From the hospital's point of view all alleged insurance patients, with the exception of those under workmen's compensation and patients who are in possession of a special policy providing hospital benefit, must be considered as potentially private. Satisfactory financial arrangements, independent of insurance connections, must be made at the time the patient is admitted if complications relative to the payment of hospital bills

In all cases, with the exception of workmen's compensation cases and patients who possess a special policy providing hospital benefit, the patient or his friends, independently of any alleged obligations of others, should provide a satisfactory guarantee for payment of services rendered. Strict adherence to this rule will minimize the problems relating to insurance

are to be averted. Strict adherence to this rule will minimize insurance problems.

There is no insurance policy written, other than those referred to, which provides for payment direct to the hospital for services rendered, except emergency first aid.

Automobile accidents today are responsible for the greatest number of patients of this type, who are classified as public liability cases. Insurance coverage on such cases provides for payment of emergency first aid treatment only. No insurance policy provides for the payment of subsequent treatment. Therefore it is imperative that at the time of receiving a public liability case the hospital admitting officer demand that definite arrangements be made for the payment of hospital service. Few policyholders, to say nothing of the public at large, appreciate the fact that an insurance company in public liability cases merely assumes the responsibility of indemnifying the policyholder if court judgment is rendered against him.

Should Require Written Guarantee of Payment

It is true, however, that when liability is admitted or when it seems advantageous to make a settlement, the insurance companies will pay a certain amount for a release. Unless the hospital executive has a definite understanding with the insurance company or with the patient, the hospital has no guarantee that it will receive any portion of the money paid in settlement.

The proper procedure in handling cases of this kind is to obtain at the time the patient is admitted a written guarantee for payment of hospital services, endorsed by a responsible person. It is com-

mon for patients of this type who believe that somebody else will have to pay the hospital bill to order unnecessary services. In these circumstances it is the duty of the hospital superintendent to advise the patient or his friends that extra services must be paid for at the time the order is given. A definite understanding at the beginning prevents many misunderstandings later.

In admitting workmen's compensation patients care must be exercised to determine the proximate cause of the disability. Patients frequently seek treatment services for disabilities occasioned in the course of employment when the employment is not the proximate cause. For example, a patient while working may develop acute appendicitis or may notice the early symptoms of arthritis. Cases of this kind are not entitled to compensation for the reason that the employment was only the occasion of the disability and not the proximate cause thereof.

In the management of insurance cases it is important to recognize the necessity for better understanding between hospital and insurance carrier. This can be brought about only by fair dealing and a cooperative educational program tending to promote a clearer knowledge of the basic principles of each service.

Accident and health policies are individual contracts between the policyholder and the insurance company. Occasionally this type of policy specifies that the insurance company will reimburse the policyholder for necessary hospital expense. Hospitals must hold this patient directly responsible for payment of the hospital bill for the reason that this type of policy under no circumstances provides for payment of hospital services directly to the hospital. It provides only for reimbursing the patient.

In the past few years a new type of policy known as the hospital benefit policy has developed. This

policy provides for payment directly to the hospital for services rendered and usually provides that the service must be rendered at the hospital designated in the policy. Great care should be exercised in accepting a patient's interpretation of this policy contract. Associated with this type of insurance is the periodic payment plan now spreading rapidly. This plan is often considered new but as a matter of fact, periodic payment plans for hospital service have been in successful operation for more than seventy-five years in California. Hospitals should be particularly cautious in entering into agreements with lay organizations selling these policies as there are numerous fraudulent concerns.

Early Arrangements Should Be Temporary

Under no circumstances should a hospital superintendent assume the rôle of a claims attorney. He should not assume that he has full knowledge of the legal liability pertaining to any type of case associated with insurance. It is perfectly right to assume the responsibility of temporary classification of the patient in the respective type of insurance coverage, but before any great amount of expense has been incurred, the hospital should have satisfactory assurance for the payment of the hospital bill from a responsible individual or a responsible officer of the insurance company.

If hospitals will establish rules requiring a guarantee of payment for services rendered within a reasonable time following admission, hospital insurance problems will be greatly minimized.

To emphasize this point, permit me to suggest that in all cases, with the exceptions of workmen's compensation cases and patients who actually possess a policy providing for payment to the hospital, the patient or his friends, independently of any alleged obligations of others, should provide a satisfactory guarantee for payment of services.

Tabulating Machines Aid in Assembling Data

The use of tabulating machines for assembling clinical data from hospitals has now become so well established in the New York Department of Hospitals that Dr. Caroline R. Martin, director of the central statistical bureau, has issued a handbook describing the method.¹ By the use of this method, Doctor Martin states, a physician can obtain in a few minutes a list of his goiter cases by age, sex, nationality, and any number of other factors. "The results of different treatments, serums, vaccines, diets and operative methods, can be compared over a period of time, and

recommendations made which may lead to the general adoption of the most successful ones."

The costs of a punch card system of records is not as great as might be supposed. The cost of the New York central statistical bureau, Doctor Martin states, averages about six cents per patient discharged by the member hospitals. Thus a hospital treating about 7,500 patients per year would have a weekly cost of \$9. Tabulating machines may be rented at reasonable rates. Where a central statistical office is not possible, through a hospital council or otherwise, Doctor Martin recommends that the services of a tabulating bureau be utilized. "Compared to the value of the system as an instrument for reducing human suffering and promoting better health, the additional advantage that it reduces operating expenses seems of little importance. Yet some of the savings may represent very substantial amounts."

¹Hospital Medical Statistics, J. B. Lippincott Company, Philadelphia, \$1.

Institutional Personality

By JOHN N. HATFIELD

Superintendent, Pennsylvania Hospital, Philadelphia

THOSE who have the idea that the greatest assurance of arousing favorable public interest is by each hospital devising distinctive and outstanding services are in my opinion correct.

These distinctive and outstanding services cannot be devised in a short period of time nor can they be maintained unless they are real and sound. Every hospital must of necessity undergo constant although in some instances hardly perceptible change. Radicalism will catch the fancy of a few — the unstable — whose patronage and support will lend encouragement to the establishment of highly publicized service features which are bound to be as short-lived as the support of that unstable group. Many hospitals have had such experience, so have hotels and business establishments. We often hear the slogan "It Pays to Advertise" — and so it does. One form of advertising will bring quick results to a business establishment while another medium will prove to be a failure. It is one thing to advertise a commodity, something possessing color, body, texture; it is another thing to advertise effectively a service that depends almost wholly upon the word "quality," something having no color, texture or body.

Patients' Good Will Is Best Advertising

The best form of advertising known to a hospital is the praise of the satisfied and grateful patient and the appreciation of anxious relatives and friends, who receive kindly and sympathetic consideration while visiting the hospital. I am a great believer in institutional personality, based on accomplishment. Institutions have been known to reflect the personality of an individual, have grown and flourished through the business lifetime of an individual, but institutional personalities thus acquired do not mature and last. They fade after the individual passes on, whose genius created and maintained the personality while he was actively a dominant part of the organization.

Institutional personality, if it possesses the features which catch the imagination and fancy of the public will live, grow and become a standard. It is built on sound and basic policies, which if early promulgated and steadfastly maintained generation after generation will live for centuries. The institutional personality once established, assumes

an individualism which is akin to that of a human personality. The kindly, charitable, benevolent nature of a hospital, once firmly established as a fact in the minds of a community is as impervious to radicalism as a human personality which develops the same characteristics. Only a long period of continued abuses from without, designed to break the spirit that lies within, can change the earned reputation of either an institution or a person.

An institutional personality is established on the basis of its relationship to the public it serves. The service provided to one community would not satisfy another. One community would for a short time support a service having an artificial, brass buttoned and chromium plated atmosphere, with little attention being given to the human side, the emotions of the anxious relatives and friends or those whose misfortunes are not confined entirely to body ills. Another community would zealously guard the reputation of a hospital which through the years had steadfastly built up its service on a foundation of human kindness. This service need not be given in a palacelike structure; there is no need for eccentricities or widely advertised hospital features, or for ballyhooed distinctive services. There should be established instead a uniform service throughout, provided by a well trained and cheerful personnel. There should be human sympathy and a spirit of neighborliness and kindly helpfulness. The hospital possessing these qualifications will receive the constant support of its community, because it is real, staunch and human. Distinctive and beyond standard services should not be sporadic and artificial, but real; not impersonal but personal.

Cleaning Building Walls

A building that is coated with noncorrosive products of combustion is a building deteriorated, even though the coating of dirt may, in fact, be protective to a degree. According to the findings of the Mellon Institute of Industrial Research, if these contaminants are carbon and ash, not accompanied by tar, they can be removed by the simple process of brushing. When tar is present, especially in the case of soot, the condition is aggravated. Steam cleaning, the use of solvents or special detergents, such as sodium metaphosphate, or scouring must be resorted to in cases where tar is present.

Editorials

"Economic Security" and Hospitals

THROUGH the advisory committees referred to in this month's news section, the professions of medicine, dentistry, public health and hospital administration have been called to assist the President's Committee on Economic Security in the study of problems and the formulation of future governmental programs concerning the losses of sickness and the questions of medical care. It goes without saying that such representative hospital men as have been assembled will approach their task with a sense of responsibility to the American people as well as to the hospitals, and that they will have the cooperation and assistance of all hospital people in this country.

The opportunity before this hospital committee is twofold: first, to offer advice on the questions presented to it by the administration's staff: in this respect the committee will undoubtedly be of service; second, to bring more fully to the attention of government officials the problems and needs of the hospitals of America and the difficulties which press upon many of them in their efforts to carry out their responsibility of rendering service to the public. The general policies under which federal, state or local tax funds should be employed for the support of medical and hospital care; the numerous pending issues of hospital service for the unemployed and the transients; the unmet hospital needs of many rural areas, are among the broad problems in which the cooperation of governments and hospitals is essential to satisfactory solution.

The set-up at Washington furthermore offers opportunity for cooperative advance along a broad front, including, as it does, advisory committees of physicians, dentists and public health administrators as well as of hospital executives. The composition of the medical advisory board indicates that progressive points of view will be well represented. A cooperative attitude is well expressed in the recent editorial in the *Journal of the American Medical Association*:

"Some physicians are apparently opposed to all change and feel that the American Medical Association should officially make itself felt in opposition to the entire program of the government. While the house of delegates of the American Medical Association has repeatedly voiced its opposition to the socialization of medical practice, it

indicated, in its sessions at Cleveland last June, its belief in properly controlled experimentation with new forms of medical practice, subject to the retention of certain basic principles recommended by its own special committee."

What is likely to be the outcome? President Roosevelt's remarks indicate uncertainty as to whether action by the federal government will be (to quote the President's words) "soon or later on." It is the common impression at Washington that federal legislation regarding medical care or health insurance will, if and when taken, be permissive only, that is, it will define certain principles or standards and offer a certain amount of federal subsidy to states which pass legislation in compliance therewith.

With the vast extent of our country and the differing conditions of its various sections, it is inconceivable that any general plan of medical care or health insurance could be administered directly as a federal enterprise. A federal legislative program of a permissive type will continue to throw the primary responsibility upon states and localities for study and experimentation. Such action by hospital, medical, industrial and other groups is essential in order that experience be gained with plans for meeting the needs of all the people who are unable individually to purchase needed care.

The hospital world may well be proud of the extent to which experimentation has already gone under its leadership, particularly the advance of group hospitalization within the past two years. In the main, these plans for hospital service have been utilized by persons of the middle class and others of modest means. Broad legislative schemes of health insurance, on the other hand, are likely to be concerned with wage workers.

The need for continued experimentation and the development of voluntary hospital plans are not lessened by the possibility of federal permissive legislation in medical care or health insurance. Rather the opportunity for effective experimentation is greater.

The A.H.A. and Federal Funds

THE most important resolution adopted at the September convention of the American Hospital Association marked a definite change in emphasis toward government payment for the care of the indigent sick. During the last year and one-half the association pressed strenuously for reimbursement from federal funds. This was done to meet a serious emergency.

Now, in part as a result of the discouraging

reception in Washington, but more because of a desire to adopt a sound long-time policy, the association has practically turned its back on federal funds. Instead it will seek state and local tax support when needed. Such a policy is in line with American precedent and with the needs and opportunities of most sections of this country. The association now asks of the federal officials that they help to educate state and local governing bodies regarding their proper responsibility to pay for the hospitalization of the indigent sick.

The association should not, of course, go to extremes in this stand. Where hospital facilities are now grossly inadequate or entirely lacking, assistance by governments including even the federal government may be necessary. Lack of hospital facilities in these regions is probably due basically to the lack of funds rather than to the lack of needs or desires.

But in those extensive areas where the hospital facilities are now adequate or nearly so the stand taken by the A. H. A. is sound. It places the major load squarely on the shoulders of the state and regional hospital associations. It is up to each association to formulate a sound and workable program whereby the local and state governments can pay community hospitals, in part or in full, for the care they furnish to the indigent sick. The program must take into account the necessity of conserving government funds and of using them most advantageously. Furthermore, it must provide an effective guarantee of the quality of service.

This is not a question to be taken lightly. If the various units of government continue to add to their general hospital facilities in the future at the same rate as they have in the last ten years, the effect on the voluntary hospitals will be far-reaching. It is up to the hospitals of each state.

Examining Interns

TOO often the meeting of the applicant for internship with the board committee is but a subterfuge, the new intern staff having in reality been selected weeks or months before.

To encourage or even allow young men and women to contest for an intern position that has already been filled is eminently unfair to them and often equally unjust to the patient. Some boards employ as a measuring stick of fitness for intern service the social, financial or political standing of the young physician. To have sprung from the wrong social level, notwithstanding personal and medical fitness, is too often wholly and definitely disqualifying. The patient cares not a whit whether the name of the intern who pays a mid-

night visit to his bed is in the social register. He craves intelligent relief from his pain or sleeplessness. If the board decides that no formal examination is to be held and that interns are to be selected wholly on personal or other recommendation, then it should announce this fact. If it desires to choose its staff as a result of a thorough personal and medical investigation, then a combined practical bedside test and oral interview would be the best plan.

The very lives of patients often depend on the judgment and fidelity of the intern staff. The most painstaking efforts of the examining committee often prove pitifully inadequate in selecting the proper group.

Hospital Suicides

SUICIDES frequently occur in hospitals. The most common means employed is jumping from high places or taking poison secured in the institution; strangulation is rare and firearms are almost never used.

The hospital is not always to be censured when suicides occur but too frequently the blame for such accidents can be laid at the door of the administrator. Lack of experience or mental obtuseness usually explains the tragic outcome when no restraining steps are employed to protect the patient from himself.

This is neither the time nor the place to detail safeguards. It is proper, however, to remark that institutional suicides should be regarded as a blot on the administrative records.

Cash or Accrual

THERE are still some hospitals which are concerned only with the funds passed through the cashier's window. Their business is conducted on the cash basis. The amount owed the hospital at the end of a year's business is a matter which is acknowledged as regrettable but easily passed as unavoidable. To conduct a retail business in such a fashion would be fatal. If cash or negotiable paper is not in the till then the goods must be on the shelf. The superintendent of the hospital should be held no less strictly accountable. If he dispenses service days, provided by the community's dollars, he should be held to account for the sums necessary to provide these salable units.

The difference between good and bad credit work is often represented by the sum remaining uncollected at the end of the fiscal year. That the

social worker should not be held responsible for the uncertainties of collection methods is readily granted. But oftentimes a patient is placed in the pay or free class without proper consideration of the facts in the case. Uninvestigated pay cases swell the total of uncollected bills at the conclusion of the year's business.

The board of trustees should closely scrutinize the circumstances surrounding each uncollected account. Frequently no charge should have been assessed at the outset. And yet, a proper computation at least of the cost of furnishing the grand total of days of service rendered is most necessary. Unless this is done the way is opened for the practice of every variety of irregularity if not actual dishonesty. An inventory of the goods purchased, and a statement of the articles sold, must be compared before the profit or loss for the year's business can be computed.

Gastro-Intestinal Therapeutics

TWO opinions exist among members of hospital boards as to the true position of the dietitian in the hospital organization. There are those who consider her a glorified cook whose chief duty is to prevent the wolf of starvation from approaching the bed of the patient during his hospital stay. Her knowledge of chemistry is looked upon as not harmful to her success but rarely by this group is it considered essential. She must first of all be able, at the least possible expense, to prevent complaints concerning the dietary. The chemical and metabolic problems concerned in treating disease by the use of food concern these persons but little. A steward usually directs the work of such a dietitian.

There are others who believe that the dietitian should be a food specialist who possesses well rounded administrative ability and experience — who is able to descend, on short notice, from calories, alkaline ash foods and weighed formulas to the inspection of garbage or to the quelling of a dispute among kitchen employees.

The presence of such a trained specialist in the hospital organization offers many splendid possibilities. The drudgery of manufacturing attractive therapeutic preparations from raw food materials is at once lightened by the entrance of definite therapeutic possibilities. The axiom that man eats to live takes on a new meaning. The metabolic kitchen becomes a necessity not a luxury when the healing properties of food are conceded. The dietitian is the doctor's aid. She should be recognized as a part of the medical personnel of the hospital.

Let the steward, if it appears practicable, prepare food for the well, but only the trained food specialist fill the dietary prescription for the sick. To do otherwise would be comparable to allowing the storekeeper to take the place of the pharmacist in filling prescriptions.

"No Checks Accepted"

MANY hospitals refuse with good reason to accept checks. This practice is increasingly frequent since within the past few years it has been difficult to differentiate between a valuable and a worthless piece of paper. But to adhere strictly to this rule is to offend some of the hospital's good friends and patrons.

Many persons are willing and able to pay hospital bills promptly. To refuse their checks is to lose good institutional supporters. A competent cashier is one who is skilled and honest and a keen student of human nature. The bungler may be financially trustworthy but so tactless with the public that the hospital's loss is often as great as if he were guilty of larceny. Classes in graciousness for key contact employees would yield large dividends on the time expended.

Protect Your Nurses

IN A hospital in an Eastern state, a nurse recently lost her life because she contracted typhoid fever from a patient whom she was nursing.

Such an occurrence is, fortunately, rare, but this infrequency of occurrence is not always the result of the practice of good preventive medicine on the part of the hospital. Frequently it is merely a fortunate circumstance. Hardly does it seem believable that a hospital superintendent would allow unsuspecting and unprotected pupil nurses to expose themselves to danger or even death by caring for a typhoid patient without vaccination. But to the shame of the hospital field this is done all too frequently.

Criminal negligence is a harsh term, but it accurately describes the behavior of hospital executives who fail to insist on the practice of good preventive medicine in the conduct of the school for nurses. Nurses have a right to immunization against typhoid fever, smallpox, diphtheria and scarlet fever. The responsibility for any morbidity or mortality among their ranks from these diseases can be placed, in the last analysis, squarely at the door of the hospital's board of trustees.

Maintenance, Operation and Equipment

Conducted by JOHN C. DINSMORE and DR. R. C. BUERKI

This Laundry's Operating Cost Is One Cent per Piece

By E. C. PARDON

Superintendent of Buildings and Grounds, University of Michigan

THE University of Michigan laundry is centrally situated among the buildings and departments it serves. The building, specially designed for laundry purposes, is of fireproof construction, reenforced concrete floors being used to support the heavy machinery. The building is 62 feet wide by 102 feet long and consists of a basement and two floors having a total floor area of 14,831 square feet and a cubical content of 256,521 cubic feet.

The laundry is situated near the power house, from which it draws electric power, steam, compressed air and all of the hot soft water used. Cold water is drawn direct from the city mains and is very hard, ranging from 22 to 26 grains. Since city water contains a considerable amount of iron

in suspension as well as in solution, the water problem is a serious one. Three water softeners are used to make the city water satisfactory for laundry purposes.

In addition to the University Hospital, the laundry serves dormitories and other buildings on the campus. The volume of work is divided as follows: University Hospital unit, 87 per cent; campus, 10 per cent, and dormitories, 3 per cent.

An average month's work consists of approximately 16,500 aprons, 10,000 baby dresses, 44,000 baby napkins, 32,000 bags, 14,100 bed covers, 10,000 bed pads, 7,000 bedspreads, 10,000 blankets, 18,000 bed shirts, 6,000 children's aprons, 9,000 children's bibs, 90,000 rags, 5,000 coats, 15,000 draw sheets, 12,000 dresses, 18,000 operating



The collar ironer, handkerchief ironer and curtain stretcher are on the second floor, where the work is sent from the washroom by means of an elevator.

 MAINTENANCE, OPERATION AND EQUIPMENT



Wearing apparel is finished in the pressing department on the second floor. This department consists of twenty-two presses of various sizes operated by ten girls.

gowns, 9,500 pajamas, 52,000 pillow slips, 60,000 sheets, 6,000 pairs of stockings, 40,500 bath towels, 150,500 hand towels, 27,000 wash cloths, 4,000 shirts and 1,000 curtains, together with a large assortment of other pieces in lesser quantities, making a total of about 700,000 pieces a month.

The pick-up and delivery service is maintained by the use of a stake-body truck operated by a driver and a helper. During rush periods it is often necessary to use a second truck.

Approximately 90 per cent of the total volume of work is white. About 90 per cent of the volume is flat work, which is ironed, and rough dry pieces, which are dried but not ironed. The remaining 10 per cent is wearing apparel that requires press ironing. Each piece is permanently identified with the name or initials of the institution stamped on it. Since there are comparatively few customers, and each piece is permanently identified, the problem of separation and sorting is a simple one.

A "U" line of flow is employed for work going through the plant. The work enters at one corner of the building, is processed, and then leaves the building on the same side at the other corner when finished.

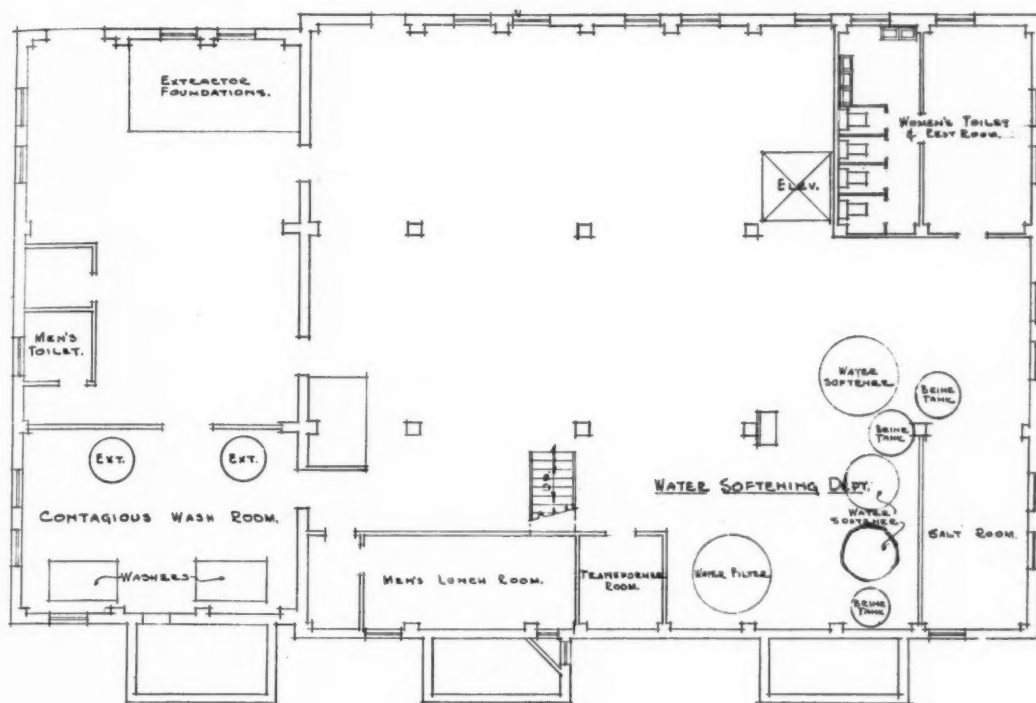
The washing department is divided into two wash rooms. The smaller one, where the pieces from the contagious ward of the hospital are washed, is in the basement, and contains two wash

wheels 42 by 84 inches and two extractors. The main washroom on the first floor washes the balance of the work. Ten wash wheels are used here, varying in size from a small pony washer to a 48 by 126-inch wash wheel, capable of washing 800 pounds of clothes per load. The bulk of the work is extracted or dried in two 54-inch extractors equipped with an electric traveling crane, which eliminates considerable labor in loading and unloading, as well as trucking the work from the wash wheels to extractors and from extractors to shaking tables or trucks for dumping. Four smaller extractors are used for extracting the work coming from the smaller wash wheels.

The flat work and rough dry pieces, which constitute the largest part of the work, are processed on the first floor. The flat work department consists of three six-roll, chest-type ironers operated by twenty-seven girls. The rough-dry department consists of five tumblers of sizes varying from a small size to a 42 by 96-inch tumbler. One man operates the machines, loading and unloading, while five girls shake out and fold the pieces.

Wearing apparel is finished in the pressing department on the second floor, where the work is sent from the wash room by means of an elevator. This department consists of twenty-two presses of various sizes operated by ten girls. Ten hand ironers are employed in "touching up" the work

MAINTENANCE, OPERATION AND EQUIPMENT

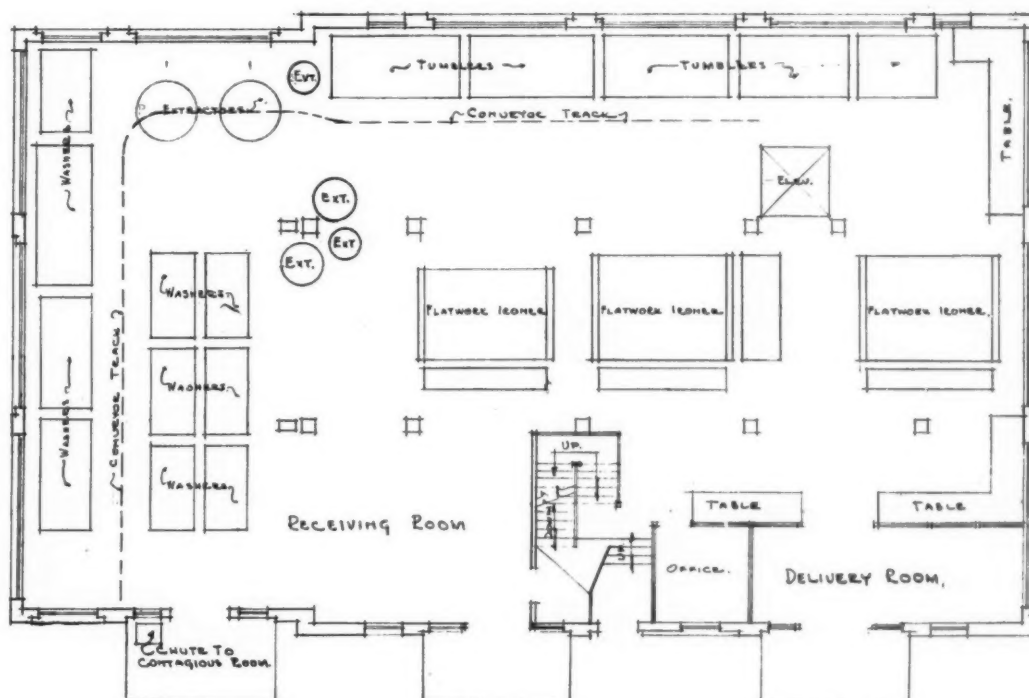


Pieces from the contagious ward of the hospital are washed in the basement of the laundry. This wash room contains two wash wheels 42 by 84 inches and two extractors.

from the presses and in folding the pieces. The curtain stretcher, handkerchief ironer, collar ironer and mending departments are also on the second floor. Sorting bins for assembling the wearing apparel bundles are near the elevator.

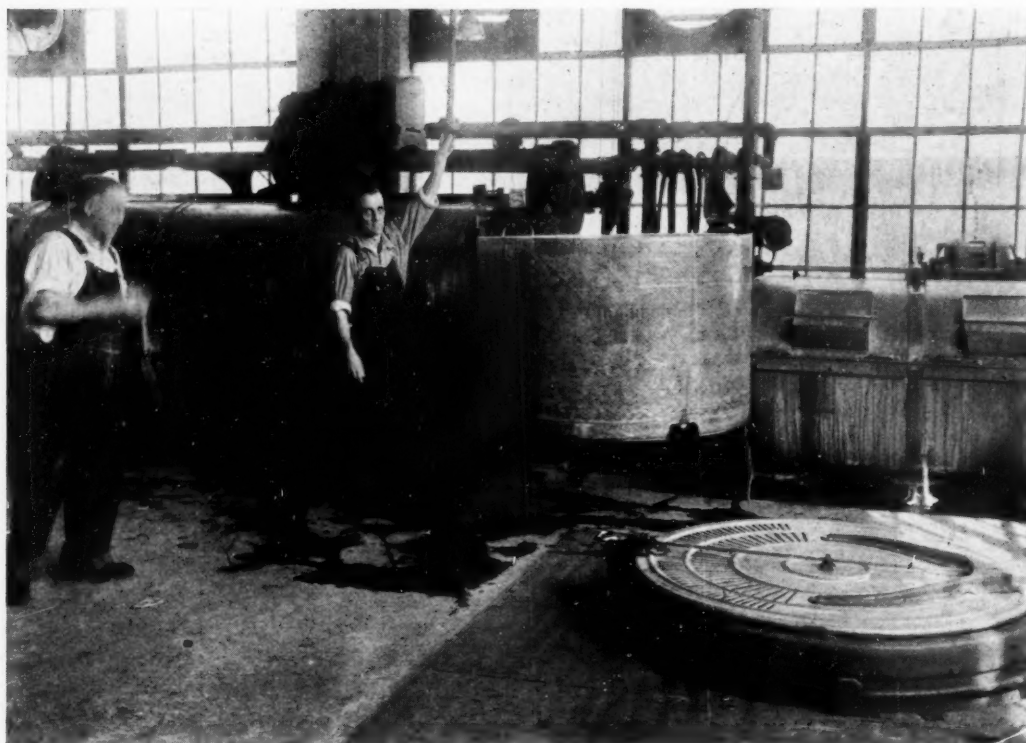
The multiple-suds washing formulas employed vary with the type and color of fabric as well as the degree of soil. One point common in all wash-

ing formulas is the low temperature of the break, or first suds. A low temperature suds will remove albumin stains, such as blood and egg stains, while high temperatures set these stains. White cotton and linen fabrics receive a washing formula employing high temperatures, a high-titer "built" soap, bleach, sour and bluing. Colored cotton and linen fabrics receive the same formula as that used



First floor plan. A "U" line of flow is employed for work going through the plant. The flatwork and rough dry pieces are processed on the first floor.

MAINTENANCE, OPERATION AND EQUIPMENT



The main wash-room is on the first floor. The bulk of the work is extracted or dried in two fifty-four-inch extractors equipped with an electric traveling crane.

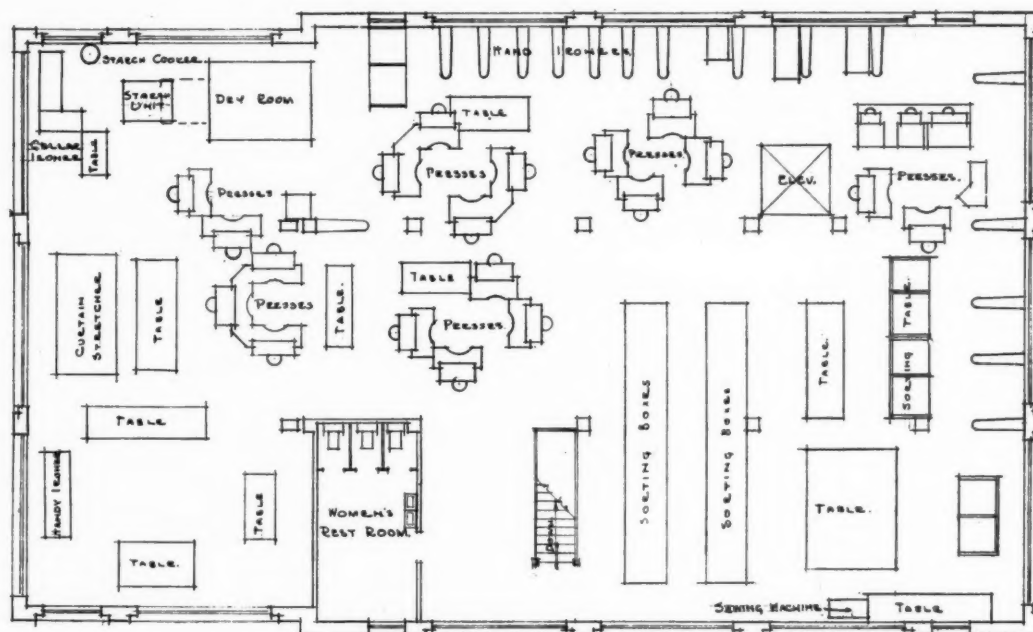
for white fabrics except that lower temperatures are used and bleach and bluing are omitted. This alteration in the formula preserves the color of the fabrics.

Silks, rayons and woolen fabrics receive a short washing formula employing low temperatures and the use of low-titer, neutral soap. Dirt adheres lightly to the surface of these fibers and they are easily cleaned, while in the case of cotton fabrics,

the dirt is embedded deep in the mesh of the fabric and requires a more strenuous washing formula. Special washing equipment is necessary for woolen pieces to ensure against shrinkage.

Rinsing or removing the soap and alkalinity from the pieces is an important factor in the washing formula. Rinsing should be carried out until the alkalinity of the last rinse bath equals that of the water supply itself. Insufficient rinsing will

This drawing shows the arrangement of the second floor where finishing is done. There are twenty-two presses and ten hand ironers are employed.





North or South, East or West,—wherever you may be during the holiday season, we again send you greetings from the home of the Wyandotte Indian. May the New Year bring you a fuller share of contentment and prosperity and as much genuine pleasure in all your business relationships as we have felt in our relationship with you!



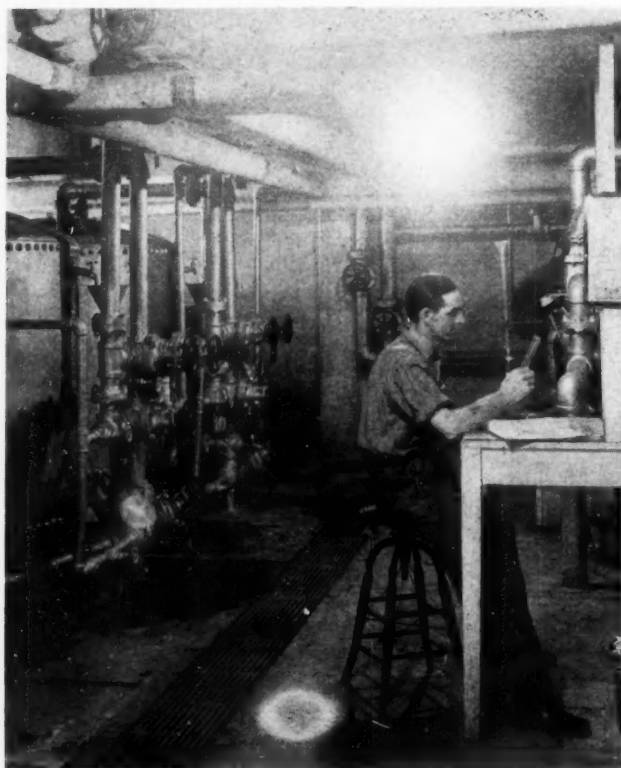
THE J. B. FORD COMPANY, WYANDOTTE, MICHIGAN



MAINTENANCE, OPERATION AND EQUIPMENT

cause discoloration or scorch during the pressing operation and is likely to cause skin irritation. Bed-ridden patients are especially susceptible to this trouble.

The multiple-suds formula, which varies for the different fabrics, kills germs that may be present. The several changes of water flush out the germs into the sewer. High temperatures for twenty minutes kill the germs. Besides, soap and bleach have germicidal qualities. When the pieces are re-



The water softening department is in the basement. Part of the equipment is shown here.

moved from the wash wheels, the germs have either been killed or flushed down the sewer.

While the laundry is under the supervision of the buildings and grounds department, it is operated primarily for the University Hospital, and every effort is made by frequent contact to serve the hospital in accordance with its requirements. In direct charge of the laundry is a general laundry foreman, who has for an assistant a technical man, a graduate of an engineering school, who also has completed a course of training at the American School of Laundry at Joliet, Ill. All the employees, with the exception of the foreman, are paid on an hourly basis, at a rate slightly higher than that prevalent in the city for similar work. Nine men and sixty-two women are employed.

A total of 8,563,734 pieces were handled during 1933, at a net cost of \$92,209.36, or an average cost of \$0.0108 per piece. No interest or taxes are paid, but approximately \$11,000 is set aside each year to pay for water, electricity and steam. Also \$5,000 to \$8,000 is set aside yearly for equipment purchase or replacement. At present the equipment inventories nearly \$120,000.

Repairs to the plant and equipment are taken care of by the buildings and grounds department, and all soap and other materials used are purchased by the university purchasing department. For the year 1933, \$64,264 was spent for labor, \$8,829 for materials, \$4,593 for trucking and \$4,333 for maintenance.

Reducing Ice Making Costs

In many of the newer hospitals there is a central circulating brine system for chilling all ice boxes and for freezing ice. While the relationship between daily ice freezing capacity and daily ice needs varies widely, it is not unusual for the freezing capacity to be several times the normal demand.

In the University of Chicago Clinics running with a little better than average occupancy the maximum daily ice consumption was four large cakes and the ice freezing capacity was forty cakes. The general practice was to pull three or four cakes of ice each day, as needed, and refill with water the three or four empty ice cans. The cold brine was constantly circulated and each set of refilled cans was frozen solid each forty-eight hours. This method was convenient but it meant that temperatures well below freezing must constantly be maintained in the large freezing vat.

A new plan is to shut down the ice freezing unit until the ice supply is reduced to twice the daily demand. Then all forty ice cans are refilled with water, the circulation of freezing brine is started and there is a brand new batch of ice sufficient to permit the shutting down of the freezing unit for another eight days. Under this plan freezing temperatures will be maintained two days out of each ten days.

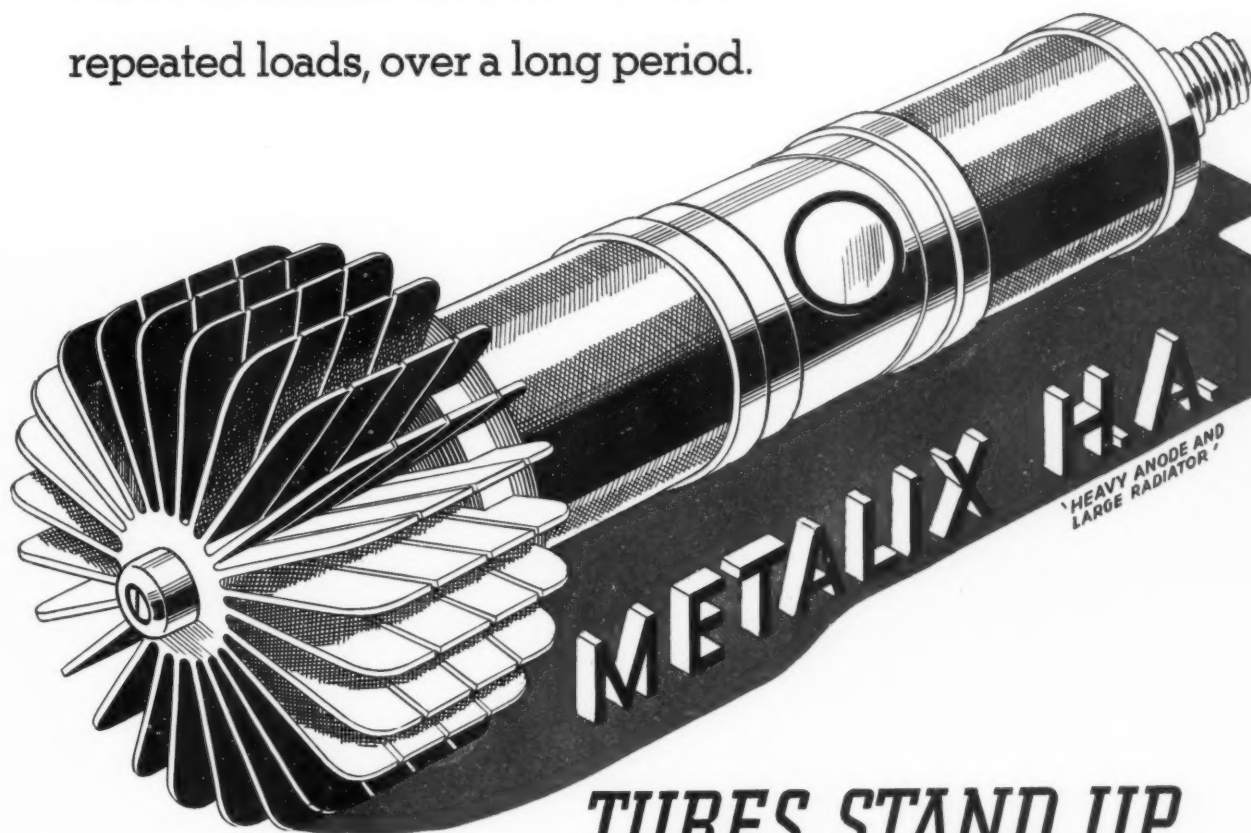
We first contemplated leaving the ice cakes in the freezing compartment in the hope that there would be little or no melting. Everyone connected with the experiment was so sure that this would not work that the superintendent finally agreed to have all forty ice cakes pulled and stored in an ice box. The disadvantage lay in the necessity of pulling the ice cakes, carting them to the ice box and carting them back to the original point for crushing.

We carried out this procedure approximately three times and then the engineer and the housekeeper both agreed that it would save labor if the ice were all left in the original containers. We find that there is practically no melting if the brine is recirculated for approximately three hours during the ten-day period.

We estimate that the annual saving of electricity resulting from this change will amount to \$200 each year.

The Economy

of an X-Ray tube is not determined by its purchase price . . . but by its ability to perform with outstanding radiographic results consistently and accurately, under repeated loads, over a long period.



TUBES STAND UP
They are Economical !

PHILIPS METALIX

300 Fourth Avenue

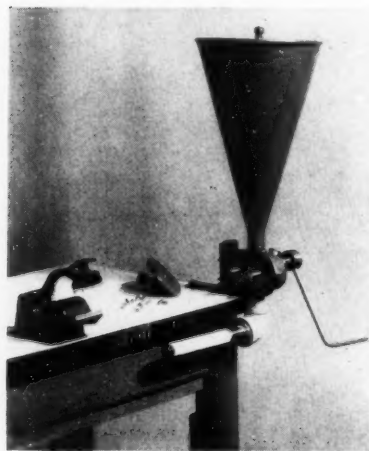
• New York City, New York

 MAINTENANCE, OPERATION AND EQUIPMENT

Simple Mechanism for Filling Collapsible Tubes

Collapsible tubes, such as are used to contain shaving cream, lubricating jelly and other preparations, may be filled by hand or by some tube filling mechanism. The large and elaborate automatic tube filling machine of the wholesale pharmaceutical house is out of the question for the hospital pharmacy. However, among the smaller types of equipment there is a certain selection to be made.

One general type is similar to a sausage stuffer and consists of a cylinder and a plunger. By means of a simple gearing arrangement on the top (similar to the old-fashioned ice cream freezer) the material is forced into the empty tubes. This type of equipment has the disadvantage of bulk and results in much waste when the equipment is cleaned. Loss also results from leakage of the ointment or jelly past the plunger. The material being inserted may become entangled in the gears; this is not only annoying



An all brass spur-gear pump with a removable plate on the side. The equipment includes a bracket to secure the pump to the table and an outlet pipe for filling the tube. The device at the extreme left seals and clips the tubes.

but it constitutes a considerable waste. The chief advantage of this type is its relatively low cost (from \$15 to \$20 with two standard spouts for the collapsible tubes).

A second type employs a reservoir and plunger pump. The ointment or jelly is placed in the reservoir and is delivered to the pump through a tube of large diameter. The plunger pump forces the compound into the tube. This method is satisfactory for large collapsible tubes. It has, however, all the disadvantages of the first type mentioned except that there is no leakage past the plunger. The cost is high and considerable difficulty is encountered in cleaning the reservoir and pump mechanism.

Of a third type is the simple and foolproof equipment that can be made by using a standard all brass spur-gear pump and a funnel shaped reservoir (to hold the material to be tubed). The gears will not permit leakage and are easily taken apart for cleaning. This simple mechanism permits the tube to be filled to any desired degree. The

cost is low, and the simplicity and efficiency are high.

In the accompanying illustration is shown an all brass spur-gear pump with a removable plate on the side. A bracket to hold the pump on the table and an outlet pipe for filling the tube are a part of the equipment. The mechanism at the extreme left of the illustration is a device to seal and clip the tubes. It closes the tube, folds the end

over and fastens the clip, securely sealing the tube.

The pump may be mounted in any position, but the one shown seems to be the best. It is important that guide pins be placed on the side of the plate so that the plate is always returned to the proper position and never reversed end for end when taken off for cleaning. If this plate is reversed, the gears do not line up properly.

The container, which is funnel shaped, may be made in several sizes. When one size is not in use, a pipe cap can be screwed on to the nipple (soldered in the bottom of the funnel) and this container set aside for use at any future period.

A series of seamless brass tubes of various sizes must be made with an adaptor to fit the discharge of the pump. Each adaptor will fit the tube sizes commonly used. These may be easily removed for cleaning purposes. A convenient graduation on the side of the table will help in filling the tubes to the right capacity.

Cleaning this type of machine is simple. The equipment is easily taken apart and all parts may be washed quickly and thoroughly without damage.

The only difficulty one might meet in the use of this machine is in attempting to handle heavy ointments, but if such preparations are heated to produce a greater degree of liquidity no difficulty will be encountered.

The total cost of this tube filler varies from \$10 to \$20.

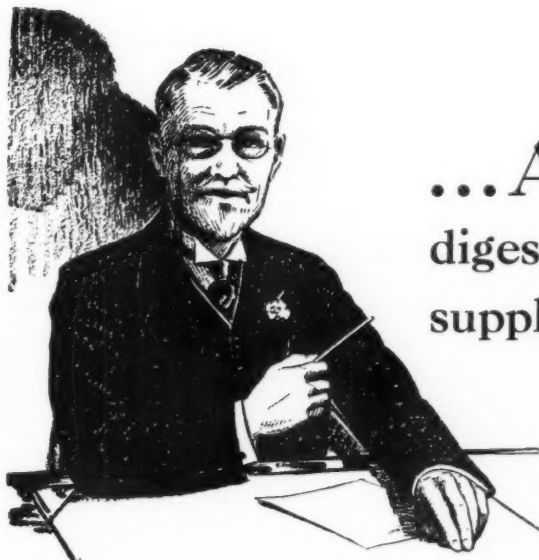
A New Use for Churns

Every hospital that uses powders in large quantities experiences some difficulty in mixing them. There are on the market many different types of powder mills but they all permit a certain amount of powder to be thrown out into the air.

It has now been discovered that powders may be satisfactorily mixed in an ordinary porcelain churn. While this technique requires several hours for adequate mixing, the procedure is simple since the churns are air tight and can be run all night at small cost. The hospital is therefore assured of perfect distribution of all the ingredients in the finished product regardless of the difference in density.

A Correction

In September in this department was a short article on "Cloth vs. Disposable Diapers," which stated that the total daily cost for 200 large and 50 small diapers is \$2.14. Some readers have interpreted this figure to cover only the depreciation cost. Actually it includes sorting and laundering, in addition.



...A safe and easily digestible carbohydrate supplement to milk in

INFANT FEEDING

KARO enjoys an excellent reputation as a milk modifier in infant feeding—and is available at an unusually low cost.

Karo Syrups are essentially Dextrins, Maltose and Dextrose, with a small percentage of Sucrose added for flavor—all recommended for ease of digestion and energy value.

To further aid the medical profession, the makers of Karo are now prepared to offer this product in dry, powdered form.

Karo POWDERED is a spray dried, refined corn syrup, composed essentially of Dextrins, Maltose and Dextrose in proportions approximating those in Karo Syrup.

For Further Information Write to:

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17 BATTERY PLACE • NEW YORK CITY



The 'Accepted' Seal denotes that Karo and advertisements for it are acceptable to the Committee on Foods of the American Medical Association.



Dietetics and Institutional Food Service

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Small Hospital Christmas Cheer

By ANNA E. BOLLER

TO THE uninitiated, the thought of spending Christmas in a hospital is at best not a cheerful one. In most homes it is the one day of the year for the gathering of the clan, and for patients, nurses and staff it is usually a sad disappointment when from necessity or duty Christmas must be spent in an institution.

Mary E. Huhn, Moses Taylor Hospital, Scranton, Pa., has voiced the opinion that of all times, Christmas is the one time of the year when the dietitian comes into her own. She may then render real service to the hospital in making the holiday

as cheerful and homelike as possible for all who must stay within its doors, both by well planned, delicious holiday meals and accompanying decorations and favors.

Much is made of Christmas in every hospital, regardless of size, but the dietitian in the small hospital has a big advantage over the dietitian in the larger institution. In the small hospital, where there are not so many to prepare for, more individual attention may be given to the favors and decorations for each tray. And the parties for nurses, employees and staff have a more personal



Three attractive favors—a gum-drop Christmas tree, a sprig of evergreen inserted in an apple and an apple Santa.

A notable advance in the science of infant feeding

Laboratory research and clinical feedings have established many striking merits for new group of Homogenized Food Combinations.

Baby foods that yield a higher amount of nutrient . . . that can be digested far more rapidly, fed earlier . . . that reduce the hazard of common digestive disturbances. Here is important news for dietitians.

Radically different

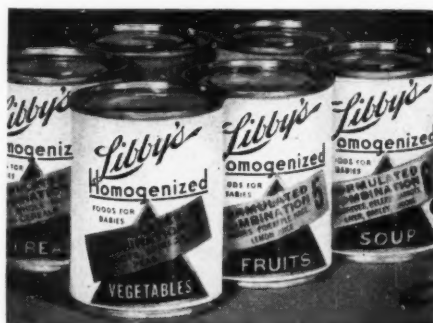
Libby's Foods for Babies are not merely sieved or strained; they are *homogenized a special way*. You know that it is the homogenization of evaporated milk which makes it so very easily digested and assimilated by babies. Now Libby has finally found a way to apply that principle to other foods so that it has the same effect on *them*. Even on fruits and vegetables and cereals.

Libby's method of homogenization refines fibers to minute particles. It actually explodes the food cells so the nutrient in them, fully exposed to the action of the digestive juices, can be *completely* digested and taken up by the body.

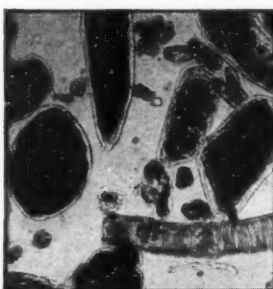
This makes digestive upsets far less likely, improves nutrition for health and growth. And it promotes normal bowel activity, for homogenization smooths and makes uniform the bulk of foods.

Combinations developed by experts

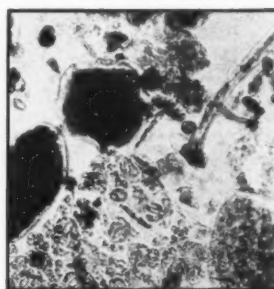
Libby's Foods for Babies are not single foods merely made more convenient; they are *formulated combinations* of foods, which have been scientifically worked out to provide a better balance of nutritional values in the infant's diet. The group includes three Vegetable combinations; Fruits; Soup; and a remarkable new Cereal unequalled in nutritive value.



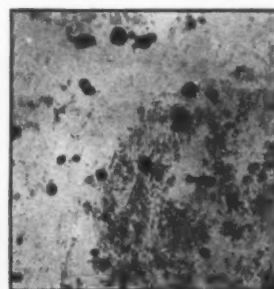
SCIENTIST'S CAMERA DISCLOSES VITAL DIFFERENCE IN BABY FOODS



Home-strained vegetables



Ordinary commercial-strained vegetables



Libby's Homogenized Vegetables

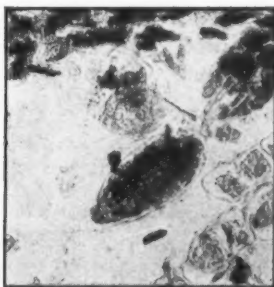
These are photomicrographs, picturing home-strained vegetables, ordinary commercial-strained vegetables, and Libby's *Homogenized Vegetables* magnified 100 times. Dark areas are food cells and fibers; note the differences in them. Since coarse

fibers and tough-walled food cells are frequent causes of digestive upsets, it is easy to understand the greater safety of Libby's *Homogenized Vegetables*. Homogenization has the same dramatic and important effect on cereal, fruits, and soup.

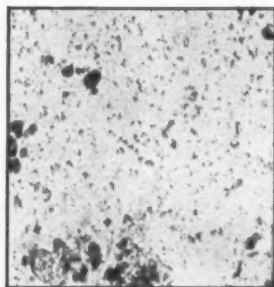
DIGESTION FAR MORE RAPID AND COMPLETE; BETTER NUTRITION SECURED



Home-strained vegetables after two hours of digestion



Ordinary commercial-strained vegetables after two hours of digestion



Libby's Homogenized Vegetables after thirty minutes of digestion!

These three forms of vegetables for babies were exposed to human digestive juices to find the time each needed for complete digestion. The photomicrographs show the home-strained and the ordinary commercial-strained vegetables with large food cells still intact, their contained nutriment undigested after two hours. You see, too, coarse

fibers which may cause intestinal upsets. Now look at Libby's *Homogenized Vegetables*, taken after thirty minutes. The cells have completely released their food content for maximum nutrition. Bulk is left in the form of fine particles which will pass through the intestines without causing irritation, yet will function for normal elimination.

Many special uses

Libby's *Homogenized Foods* are not only ideal for infant feeding. They may be used to advantage in colitis, gastro-enteritis, and post-operative cases. They are also well adapted to the needs of cases of malnutrition and expectant mothers.

Send for pamphlet The full story of

the research and clinical findings about these new foods should be of great interest to every dietitian. An authoritative pamphlet, giving the story in detail and a complete analysis of the nutritive values of each food, will gladly be sent free upon request. Address Dept. 12-H, Libby, McNeill & Libby, Chicago.

Libby's Homogenized FOODS FOR BABIES

Unseasoned except for salt. Packed in enamel-lined cans

touch, because the group is smaller and better acquainted.

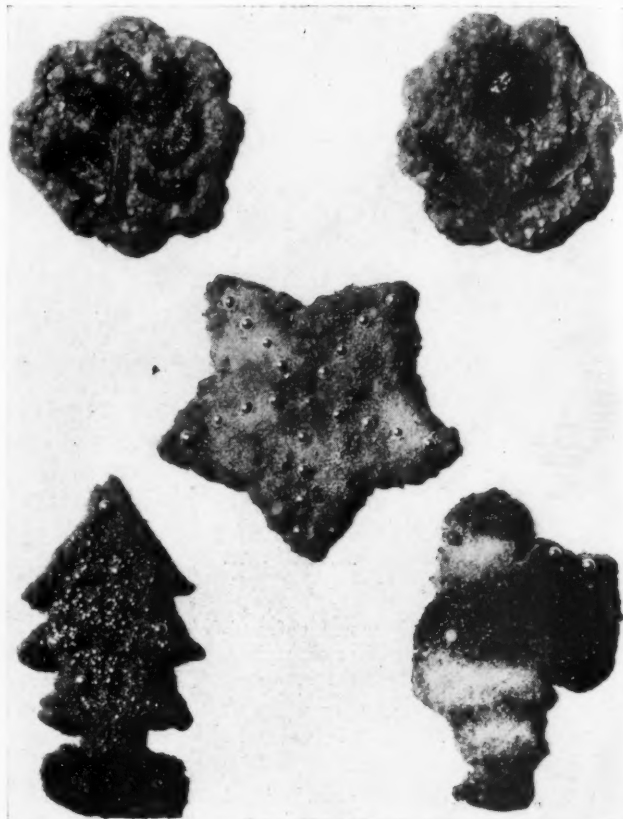
As Miss Huhn says, although Christmas is such a busy time, there is so much pleasure to be gotten out of the work and plans, and the happiness brought to others, that few dietitians would choose to have their vacations at this time. This spirit of getting pleasure out of the Christmas preparations is evident in all of the plans here outlined by a number of small hospital dietitians.

The wise dietitian, knowing that the regular daily routine must go on, Christmas or no Christmas, and that the making of favors and decorations, even though it is fun, means considerable extra work for many whose days are already very full, will begin her Christmas preparations a month or so ahead of time. Then there will be no last minute rush, or burning the midnight oil to finish things in time.

Leta B. Linch, Lincoln General Hospital, Lincoln, Neb., states that at her hospital preparations start early in the fall. The stockings to be filled with candy and nuts are cut out of tarlatan and given to patients, faculty members, student nurses, student dietitians, or anyone who is interested, to be buttonholed in brightly colored yarn.

Frances Ross, Decatur and Macon County Hospital, Decatur, Ill., describes a clever souvenir menu, which could be prepared some time in advance. A linoleum cut is made in any Christmas pattern, and printed on red or green paper at small cost by a local printer. The student nurses or student dietitians then print the Christmas menu on the inside, together with a cheery greeting.

In Moses Taylor Hospital, the student nurses begin to make fruit cakes in the diet kitchen, as

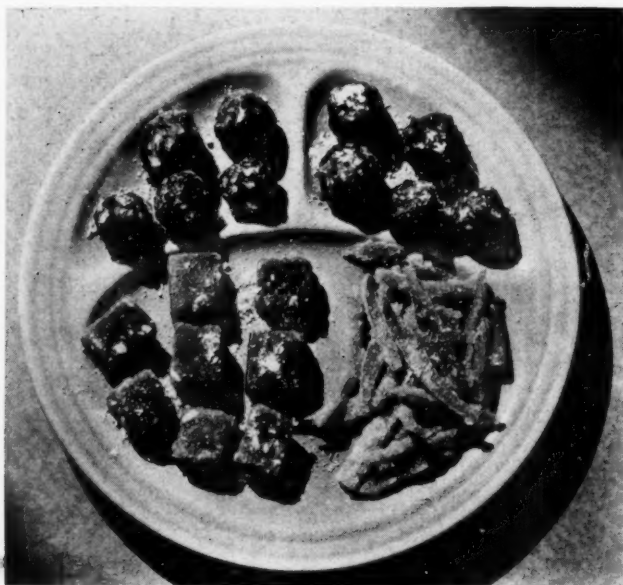


Simple decorated cookies will delight the children without the danger of "holiday upsets."

early as the first of November. Small cakes are made to send to the affiliated students in New York City and Philadelphia. These are gaily wrapped and included in a box of nuts, candies and other goodies, with an original poem, to gladden the hearts of the girls who must be far from home for the holidays. In the large cake, which is destined for the nurses' Christmas party, a ring, bandage, thimble, dime and wishbone are placed, to cause a good deal of merriment when the cake is cut and the "fortunes" discovered.

Joan Seaman, Muirdale Sanatorium, Wauwatosa, Wis., also stresses the advantages of starting the Christmas preparations far in advance of the holiday season. Here, too, fruit cakes are baked in November, and work is begun on window and table decorations, to be taken up in spare moments. Festivities begin about two weeks before Christmas, when a group of three live evergreens, so placed that every patient has a view of them from his window, are lighted with brightly colored lights.

Another excellent suggestion for the Christmas season is presented by Miss Linch. She suggests "spreading the celebration over several days." At Lincoln General Hospital, they lead up to the Christmas celebration, by starting with the supper trays on December twenty-third, when a Santa



Fruit candies are a pleasing addition to the menu.

2½ Times *Richer* in Vitamin B

Ralston Wheat Cereal — enriched with wheat germ — does double duty as a cereal for all the family.

IT provides in one tempting, delicious food the abundant body-building elements of whole wheat (only coarsest bran removed) — and two and one-half times the quantity of vitamin B normally found in whole wheat.

Ralston is complete, ready to prepare. It ends the extra trouble and expense of separate products which supply only vitamin B — cooks in five minutes and costs less than one cent a serving.

For the Research Laboratory Report and samples of "double-rich" Ralston Wheat Cereal use the coupon below.



RALSTON PURINA COMPANY, Dept. MH,
440 Checkerboard Square, Saint Louis, Missouri.

Please send me a copy of your Research Laboratory Report and samples of "double-rich" Ralston Wheat Cereal.

Name _____

Address _____

This offer limited to residents of the United States.

Claus cookie appears on each tray. This arouses an anticipatory thrill in the patient, and swings the employees and nurses into the Christmas spirit, and at the same time spreads the extra work over several days, instead of concentrating it all on December twenty-fifth. On Christmas Eve perhaps a cup cake iced in white and decorated with a citron Christmas tree, is served.

At Muirdale Sanatorium, a tuberculosis sanatorium, they also carry out the idea of spreading the Christmas celebration over the whole week. Several days before Christmas, the older children dramatize a Christmas story for the younger ones, and in return, the little ones put on an entertainment for the older children. After the program, Santa Claus arrives with popcorn balls for all.

All over the world, Christmas Eve is associated with candles, and if there is no window in which to place one, a lighted candle on the tray will serve as a nice substitute. The tiny birthday cake candle, stuck into a marshmallow or gum-drop, with a "lifesaver" tied on as a handle is not a new suggestion, and has been used in many institutions, but it is so simple to make and so effective that it is again called to your attention. Mable Rusk, St. John's Hospital, Red Wing, Minn., has used a little larger red candle, stuck on a 4-inch square of green cardboard, by melting the end a little, which is even more simple.

In many small hospitals, choir boys from near-by churches come on Christmas Eve to sing carols in the halls. This is a lovely custom, which brings a great deal of pleasure to both patients and nurses, and the boys will feel well rewarded and be sure to "come again next year," if a "feast" of hot cocoa and Christmas cookies is served at the end of the performance.

Another cheery custom observed in Moses Taylor Hospital is for the nurses to go through the wards carrying lighted candles and singing carols on Christmas morning. After this they have their own Christmas breakfast at gaily decorated tables. One simple suggestion for the nurses' dining room

is a large green holly wreath, with a tall red candle in the center, as a decoration placed in the center of each table.

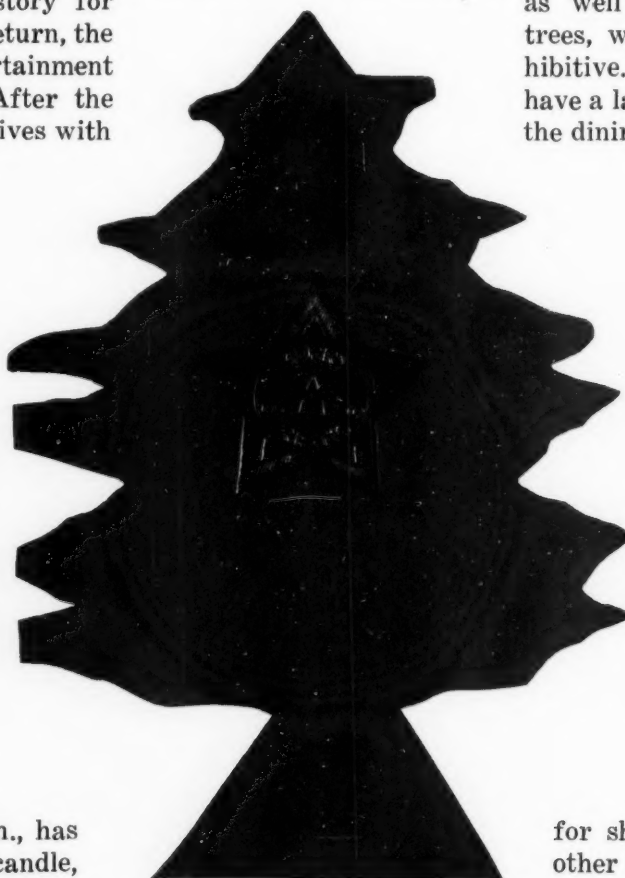
The dietitian who must watch her budget carefully in these days of rising food prices, need not cut down on Christmas decorations, for almost anything she needs may be purchased at the ten cent store. Red and green crêpe paper can be used in innumerable ways for decorations and streamers from electric light fixtures, and strips of the paper along the tables over the white cloths are very effective. Bowls of fruit are always attractive as well as the small Christmas trees, where the price is not prohibitive. If possible, it is nice to have a large Christmas tree both in the dining rooms and in the wards.

Dorothy I. Anderson, Iowa State College Hospital, Ames, Iowa, tells us that the prospect of ten days' vacation generally effects some miraculous cures in a college hospital, so that that institution is often comparatively empty, and therefore a vacation can be given to many of the nurses and members of the staff. However, an effort is made to make the holiday a happy one for those who must stay on the job.

Miss Anderson suggests an attractive plan for sharing candies, fruits and other sweets received from friends and relatives. These are

all placed on one table in the nurses' dining room, where they are available to all for a special treat after meals during the holiday season, or when anyone is going off duty.

Miss Seaman says that the problem of decorations is a little different in a tuberculosis sanatorium. At Muirdale a large Christmas tree is placed in the main dining hall, with two smaller trees on each of the three floors of the main building, and two in each of the four cottages. The trees are all beautifully decorated with lights, ornaments, tinsel and icicles by patients under the direction of the staff of the occupational therapy department. Wreaths are hung in all of the windows of the dining room and in as many other windows as possible.



Newly Discovered!

An Active Laxative Agent in Prunes

All Prune-foods—even prune juice which has no crude fibre—are now known to stimulate peristalsis. Science has verified these facts. Mail coupon for report.

HERE IS SUMMARY OF THE MOST RECENT RESEARCH ON CALIFORNIA PRUNES

1. PRUNES NOW KNOWN TO CONTAIN AN ACTIVE LAXATIVE AGENT in addition to THE SMOOTH BULK THEY PROVIDE. No other fruit or food, including all those supplying roughage is now known to possess the principle present in California Prunes. This makes them doubly effective in stimulating intestinal action.

2. PRUNES DO NOT AFFECT THE ALKALINE RESERVE OF THE BLOOD. As much as 200 grams (18 prunes) per day in the usual diet does not significantly affect either CO₂ combining power of blood plasma or hydrogen ion concentration of the urine. The potential alkalinity of the ash of prunes is 24.4 (cc normal acid per 100 grams of prune flesh).

3. PRUNES CONTAIN IMPORTANT VITAMINS IN SIGNIFICANT QUANTITIES. California Prunes (as sold) are a good source of vitamin A (500 Sherman units per ounce of flesh); good source of vitamin B (22 Sherman units); and an excellent source of vitamin G (80 Sherman units).

4. PRUNES CONTAIN ESSENTIAL MINERALS. Considerable amounts of mineral elements are contained in California Prunes, including calcium, potassium, phosphorus, sodium, iron, magnesium, manganese, copper, chlorine and sulphur.

5. PRUNES ARE RICH IN IRON AND COPPER. It has been determined (according to controlled animal study) that prunes are among the outstanding fruits highest in iron and copper content, and are acquiring increasing importance in the dietary because of these two valuable elements.

6. PRUNES HAVE HIGH ENERGY VALUE. California Prunes are an excellent source of quickly available food energy owing to their high content of assimilable sugars. These sugars, being monosaccharides, quickly provide food energy for relieving fatigue due to lack of energy food or to excessive demands upon stored energy.

(A bulletin, "The Nutritive Values of California Prunes," describes the above program in greater detail. A copy will be gladly furnished on request. See coupon.)



Until recently it was thought that the intestinal stimulative effect of prunes was due entirely to the well-recognized action of the whole fruit. But the medical profession, having been advised of the results of an intensive investigation on the nutritive properties of the fruit, now knows that a second laxative property is contained in prunes: a *naturally active substance*, soluble in water, alcohol and pyridine. So distinct is this second laxative "agent" from the bulk, that it is present in effective quantity in all forms of prune foods such as prune bread, prune whip, etc., and even in prune juice, from which all fibre is, of course, lacking.

Thus, the recipe for Crusted Prune Betty shown here, provides, among other things, this double intestinal stimulation and, at the same time, offers variety to the diet at low cost.

Also shedding new light on prunes as a dietary treatment, was the discovery that prunes did not affect the alkaline reserve of the blood. It was supposed at one time erroneously, of course, that because of the presence of benzoic acid in the fruit, acid residues were produced under digestive action. The *reverse* is actually the case.

Indeed, the results of the most recent scientific research reveal prunes in a more favorable light than ever before. A summary of this work is given here and a booklet describing the detailed results of this research will be gladly forwarded upon request. (See coupon.)

A new Manual has also been prepared, describing the place of this delicious fruit in special diets. It is practical and will be helpful to everyone in any way connected with the planning of patients' meals.



A Suggestion: Crusted Prune Betty

(Serves 125)

7½ quarts cooked prunes
7½ quarts chopped cooking apples
20 quarts toasted bread cubes
2½ quarts liquid from prunes
¾ quarts water

¾ quarts granulated sugar
¾ tablespoons salt
¾ tablespoons cinnamon
1¼ pints butter

Pit prunes and cut into medium sized pieces. Place half of bread cubes in greased baking pans, add a layer of prunes, a layer of apples, then remainder of bread cubes. Combine prune liquid, water, sugar, salt,

cinnamon and butter in a kettle; bring to a boil and let boil 2 or 3 minutes. Pour evenly over the bread. Bake in a moderate oven (375 degrees F.) 1 hour or longer, depending on depth of pans.

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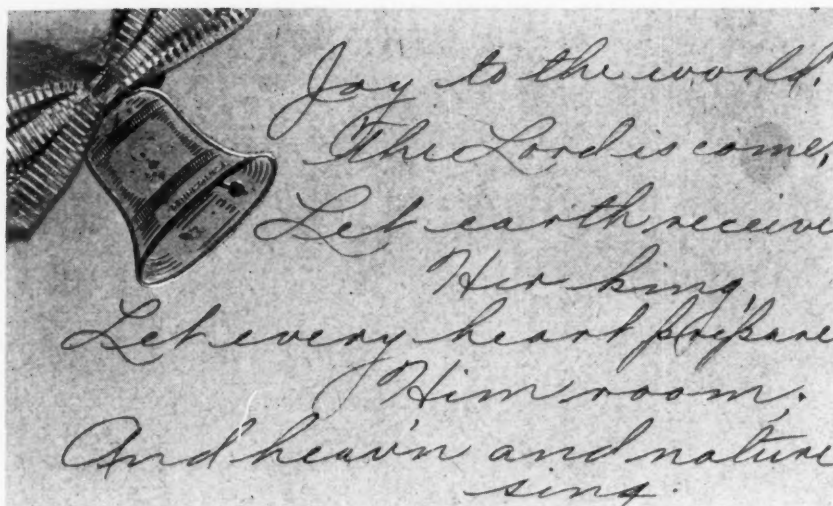
- ☐ Bulletin on The Nutritive Values of California Prunes.
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- ☐ New California Prune Diet Manual.
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The tray card at the left is light blue with a silver colored bell and blue and silver ribbon. The roast turkey below is garnished with oranges and candied cranberries.

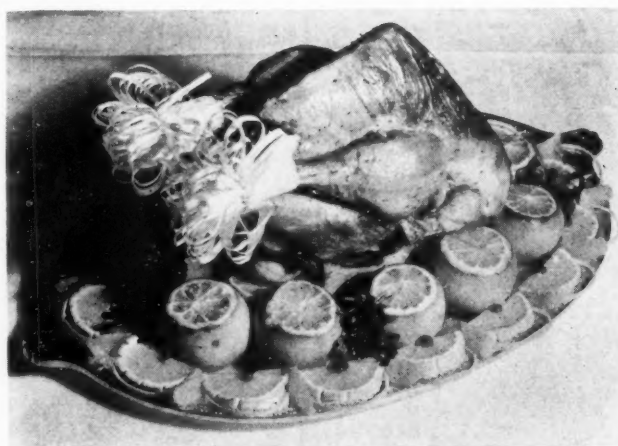
The breakfast, dinner and supper trays for the patients are made as attractive as possible in all institutions. Bright paper napkins with attractive Christmas designs are sometimes used, or a sprig of holly is tucked into the folded white napkin to add a festive touch. Most hospitals place a greeting card on the breakfast tray.

The dinner tray can be enlivened by a Christmas nut cup, or a tarlatan stocking filled with candy, nuts, mints and stuffed dates and topped with a sprig of holly. A cunning gum-drop Christmas tree is quickly made by cutting a gum-drop cross-ways in four slices, and arranging the slices on a toothpick, the largest at the bottom, the smallest at the top. The toothpick may be stuck into a red gum-drop, which will serve as the base. An apple Santa Claus will always provoke a laugh, and can be eaten when the patient is tired of looking at it. These are made by using a small red apple for the body, a marshmallow for the head, long gum-drops on toothpicks for the arms and legs, with halved round gum-drops for the feet. Cloves make the eyes and nose, and cotton is placed around the neck and down the front, held in place by clove buttons.

Another funny little Santa Claus is made from a peanut. A red paper suit is pasted on the peanut, trimmed with a black paper belt. A red conical cap is pasted on the head and a face is inked on; cotton makes flowing white whiskers, and toothpicks the arms and legs.

Decorated Cookies Please the Children

It does not take much to please the children, and a wise dietitian keeps her Christmas favors simple and well in line with sound nutritional ideas. Simple cookies, decorated as are those illustrated will delight the children without the danger of "holiday upsets." The recipe for such easily prepared cookies is given here.



An inexpensive but attractive favor is made by inserting pieces of real Christmas trees into the tops of bright red apples. Decorate the trees with artificial snow and miniature candies.

Bess Gatton, Robinwood Hospital, Toledo, Ohio, suggests still another use for the apples. She selects bright red ones, polishes them well, and inserts red candles about 2½ inches long in each.

Miss Linch suggests the happy custom of having the student nurses or dietitians call on each patient after breakfast on Christmas morning, to wish him a merry Christmas, and to deliver a little tarlatan stocking filled with candy and nuts. This

OATMEAL CUT-OUT COOKIES

2 cups quick cooking rolled oats	½ cup shortening
1 cup brown sugar	¼ cup boiling water
½ cup white sugar	1 teaspoon soda
1 cup flour	¼ teaspoon salt

Combine oats, flour, sugar and salt, stir in melted shortening and mix thoroughly. Add soda dissolved in boiling water. Roll very thin and cut into Christmas shapes, using Santa Claus, Christmas tree and star-shaped cookie cutters. Bake in a hot oven 5 to 8 minutes (until a golden brown). Decorate with colored sugar, and candied cherries and citron. Yield—6 dozen cookies.

EXCERPTS REPRINTED FROM THE CHEMICAL
LABORATORY NOVEMBER 24 ISSUE OF THE
JOURNAL OF THE AMERICAN MEDICAL
ASSOCIATION, PAGE 1621

Aseptic-Thermo Indicators, manufactured by the Aseptic-Thermo Indicator Co., also of Los Angeles, are products designed for determining effective sterilization of certain types of materials. The products are designed for inclusion in or near the center of packages of goods for pressure-steam sterilization to determine whether or not adequate sterilizing conditions have been met throughout the depth of the material . . .

The Aseptic-Thermo Indicator . . . consists of a lavender arrow pointing to the figure 250° on a green dial. Under conditions as outlined . . . the arrow matches the dial in color.

The . . . devices were called to the attention of the A. M. A. Chemical Laboratory by Dr. T. B. Magath of the Mayo Clinic, who had conducted a study of the Aseptic-Thermo Indicator. A small autoclave, susceptible of being heated to the desired temperature within thirty seconds and of being exhausted of steam and water in ten seconds, was constructed. The time and temperature recordings for this instrument were of established accuracy within limits, respectively, of ± 5 seconds and ± 0.5 C. With this apparatus, Indicators being selected at random, Dr. Magath obtained the results shown in table 1.

Twenty-five Indicators were used. After nineteen minutes the lavender color deepened to purple, yet Dr. Magath reported that the change to green did not occur until twenty minutes had elapsed, at which time all Indicator arrows matched their green dials. When the test was repeated at 126 C., the same condition obtained, except that the change occurred at sixteen and one-half minutes, again with all Indicators. In ascertaining the part played by moisture, twenty-five Indicators were submitted to dry, hot air at 170 C. for five hours. No change in color occurred. Because of a forty-second lag in the apparatus, the time recorded for color change to occur was considered as correct only within a possible error of ± 40 seconds (or a maximum error of eighty seconds).

TABLE 1.—RESULTS OBTAINED WITH ASEPTIC-THERMO INDICATORS.

Minutes	Steam at 15 pounds pressure Temperature	Results
10	121 C.	No change in color
12	121 C.	No change in color
14	121 C.	No change in color
16	121 C.	No change in color
19	121 C.	No change in color
19.5	121 C.	No change in color
20	121 C.	Color change to green (matched)

Except for that relatively inconsequential source of error, the work appears to be critical, precise and conclusive. The conclusion drawn is very broad and seemingly justifiably so:

These Indicators are satisfactory for testing sterilization with steam under pressure for all uses in bacteriologic laboratories and hospitals.

Under the auspices of the A. M. A. Chemical Laboratory, a further investigation of the products was undertaken. This was performed in the laboratory of, and in collaboration with, the department of bacteriology of a well known medical school.

TABLE 2.—DESTRUCTION OF MICRO-ORGANISMS

Duration of Autoclaving	Culture B. Welchii	B. Subtilis	Appearance of Indicator Aseptic-Thermo Indicator
A. 5 minutes	+	+	No change
B. 10 minutes	+	+	No change
C. 20 minutes	—	—	Arrow still slightly reddish
D. 30 minutes	—	—	Matched

The work was directed, roughly, toward investigating the various claims of the manufacturers as well as establishing a fair estimate of the reliability of the products.

The first experiment consisted in an investigation of the . . . products in autoclaves of two types (i. e., direct steam supply and gas-heated individual generators) and of various sizes. Conditions of temperature, pressure and duration of exposure were varied, as well, but constant for a given experiment. Twenty-three determinations were made, with the finding that no change in color of . . . the Indicators . . . took place unless standard sterilizing conditions were met (20 pounds pressure of live, saturated steam for ten minutes of actual contact with the products). The variable, of course, is the time required for the penetration of steam into the packages being sterilized. In some instances, complete color change did not occur even though the so-called standard sterilizing conditions had obtained. This might be looked on as an additional margin of safety over and above the usual factor of safety in efficient sterilization.

The second experiment had to do with establishing whether or not complete color change indicated absolute destruction of all micro-organisms, including spore-formers. For this purpose one-centimeter squares of absorbent paper (Kleenex) were saturated with old broth cultures of *B. subtilis* or *B. welchii* and placed, one or the other, in sterile Petri dishes with . . . an Indicator. . . The results are given in table 2. The conclusion, of course, is that a complete color change or "matching" of the Indicators is evidence of complete sterilization. . .



PROVED!

THIS MODERN TECHNIQUE FOR DETERMINING EFFECTIVE STERILIZATION

Aseptic-Thermo Indicators have for many years met with the approval of hospitals as an economical, simple and effective check on pressure-steam sterilization. Now comes a report by The Chemical Laboratory of the Journal of the American Medical Association, excerpts from which are printed at the left.

Here are authoritative and convincing facts on Aseptic-Thermo Indicators—tests and conclusions that prove their value and reliability in hospitals. Read over these statements. Then write to us for further details. Aseptic-Thermo Indicators are simple in principle and extremely low in cost.

ASEPTIC-THERMO-INDICATOR CO.
A. G. BARTLETT BUILDING
LOS ANGELES, CALIFORNIA



SUMMARY

The foregoing indicates that (the) . . . Aseptic-Thermo Indicator is efficient in determining sterilization by the autoclave. . . . Whenever color change had proceeded to the point of matching, sterilizing conditions had been met sufficiently to result in the destruction of all micro-organisms, including spore-formers . . .

personal touch would mean much to the patient who was feeling just a little blue at being away from home on Christmas.

Miss Ross has a happy suggestion for the patient who is hoping for Christmas visitors. Two guest trays are allowed without charge to each patient on Christmas day, so that if it is possible for friends or relatives to be with him, he will not have to eat his holiday dinner alone.

Miss Huhn recommends that a radio or phonograph be obtained for each ward, to help pass the day with Christmas music.

While every dietitian has a stock of favorite Christmas recipes, she is always on the look-out for something new. Rachel Ball, McLeod Infirmary, Florence, S. C., suggests the use of cornbread for a delicious turkey dressing.

Miss Ross describes an attractive Christmas salad, made in the shape of a holly wreath. A ring of pineapple is covered with chopped parsley for leaves, and bits of pimento for berries, tied with a large pimento bow.

During the week between Christmas and New

Year's Day the party for the nurses is usually held. At Moses Taylor Hospital, they have their own tree, with gifts for all from the ten cent store. The interns and students are invited, a play or program of some sort is planned and the evening ends in dancing and singing carols. Sandwiches, cocoa and fruit cake are served.

Miss Linch suggests a Christmas party for the employees as well. She usually tries to plan this as a surprise, and arranges for a tree, a program and some little gift for each one. Simple refreshments are served and the dietitians and nurses all help. Miss Linch finds that this creates a fine spirit of cooperation, and in the general fun many little differences are ironed out and the New Year begun with a feeling of happiness all around.

Thus the dietitian in the small hospital will find that the results of a little extra work and planning for the holidays are far-reaching, both in the way of giving comfort, satisfaction and happiness to patients, and in establishing a spirit of friendliness and cooperation among nurses and employees, and she will be mighty well repaid for her trouble.

Segregation of Diabetics Simplifies Feeding

By MAUD MARGARET ANDREWS

Norton, Vermont

IN THE average hospital the diabetic patient presents a more or less complex problem. This is true even of ambulatory patients who are admitted for diagnosis and treatment. It seems that the routine necessary for their comfort and care has been given less thought than has that for average patients.

In many instances, especially in the small hospital, when the patient arrives no person seems to know just what is expected of him. This is due to the fact that a period of possibly two months may have elapsed between cases. Few hospitals seem to have simple standing orders designed to apply in all instances except comatose cases, pending the arrival of the attending physician.

Many diabetic patients, who possibly cannot afford to go to the larger centers where the best treatment and educational facilities are available, filter through the general hospital. They are admitted into wards with other patients. Accident victims and patients recovering from general anesthesia are extremely trying to diabetic patients in whom nervousness is an outstanding symptom. Often this situation results in a more or less seri-

Miss Andrews suggests that every hospital set aside a few bright airy rooms for diabetic patients. An isolation ward, kitchen and laboratory should be included in the unit so that special instruction can be given patients under ideal conditions. Feeding is simplified when diabetics are segregated from other patients

ous upset that must be overcome before routine treatment can be established.

In addition these patients are placed on a diabetic diet, generally more or less restricted for the time being, while other patients are being served the full diet. For those who are unfamiliar with routine the situation is difficult to grasp

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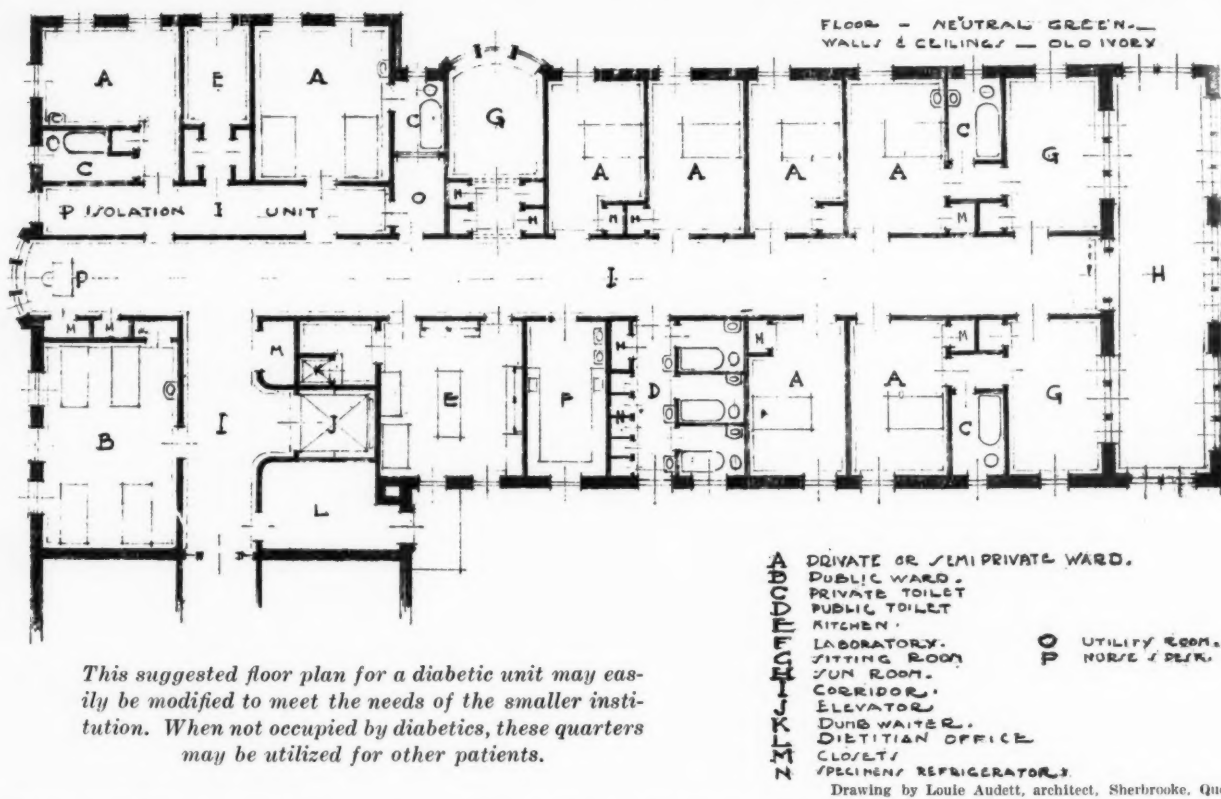
Service detects fire at the first breath of flame and notifies hospital officials and the fire department quietly, quickly and accurately. Trained forces are summoned in those first precious seconds when the blaze can be extinguished without alarming patients and before serious damage can result.

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This suggested floor plan for a diabetic unit may easily be modified to meet the needs of the smaller institution. When not occupied by diabetics, these quarters may be utilized for other patients.

Drawing by Louie Audett, architect, Sherbrooke, Quebec.

at first, and these patients consequently get the impression, in some cases, that they are being more or less hoaxed. Their fellow patients pity them and generously offer portions of food, or their friends get conscience stricken and bring them a few tidbits, which makes more difficult the problem of those who are trying to do conscientious work. Patients who have a true diabetes mellitus often have no pain and consequently feel that there is no immediate danger. This attitude adds to the problem of handling them successfully.

The twenty-four-hour urine specimen is usually kept in the duty room and there is always danger of accident before it reaches the laboratory. No matter how good laboratory facilities may be, the links of the chain must be well forged under these conditions if accidents and errors are to be avoided.

If diabetic patients can be assigned to private rooms or to wards equipped for this purpose, the battle is half won. The equipment for such a room need not be expensive or elaborate, and can be transferred from one room to another in case patients are few and far between. Under these conditions patients' specimens, which are so important, can be more satisfactorily collected, thus avoiding errors that often result in loss of a patient's time and annoyance for the physician. Food is usually considered adequate when it is not compared with a full tray, until these patients are trained and their viewpoint becomes more or less

adjusted. The days of starvation are over, or should be, but the problem of educating patients remains. One of the most important factors in the treatment of diabetic patients is the fact that they have a thorough understanding of their condition and how to control it—that is to say, they should know what their glucose tolerance is and they should be able to maintain that tolerance, or approximately so, through the medium of exchange of equal values.

There are many beautiful new hospitals still in the embryonic state and others under construction. Surely each hospital could set aside for diabetic patients a few airy rooms, with plenty of sunshine and an isolation ward, kitchen and laboratory where special instructions could be given these patients under ideal conditions.

The accompanying floor plan for a diabetic unit is the result of a number of years' observation and rather intensive study of these conditions, and may be modified to meet the needs of the smaller institution. When not occupied by diabetics, these rooms or wards could always be utilized for other patients, for example, obesity or gastro-intestinal cases.

The isolation ward for advanced cases of diabetes mellitus with infection and other complications relieves other patients, visitors and workers of a great deal of discomfort, and eliminates many erroneous ideas that visitors often carry away about hospital ventilation and other conditions. In many instances the same rooms could be used for

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HEADQUARTERS FOR MEDICAL SUPPLIES OF ANIMAL ORIGIN

the isolation of other infectious cases where more or less complete isolation is desirable. Many hospitals appear to make little or no provision of any kind for emergency isolation cases that must remain in the building or that they may think it wise to retain.

The remainder of the floor is occupied by a sun parlor, a reading room, two suites that can be converted into private rooms with bath, private rooms, semiprivate rooms, ward, kitchen, laboratory and general bath with fitted cubicles. The large refrigerator in the general bathroom will take care of all specimens from the floor.

The kitchen, while equipped for teaching purposes, can be used for a distributing station as well. Emergency laboratory work and patient demonstrations can be taken care of by the same laboratory.

Dressing trays and linen are provided for by large cupboards outside the reading room en-

trance. These cupboards contain enclosed dressing trays.

The duty room has been purposely omitted from the main hall, and should appear on the bridge, beyond the dietitian's office.

The feeding of diabetic patients is fairly simple, once regular routine has been established and a system of work has been agreed upon by those most concerned. There are many good basic systems in use in the larger hospital centers and research hospitals. Presbyterian Hospital, Chicago, has one of the best. The food itself should be of the best quality available in order that patients may enjoy and utilize their complete ration. Simple plain foods, well prepared and accurately weighed, are best. Most dietary prescriptions today are liberal enough to ensure three good meals with plenty of bulk, and sufficient carbohydrate to ensure a tasty bit of some kind of dessert. A few periods of instruction on food combinations,

food values and methods of preparation — with facilities at hand with which to work, such as the small kitchen shown on the plan at "E" will enable these patients to obtain a clear insight into their food problem.

Few persons cannot make change for a dollar. In order to do this they must be familiar with the component parts. Why should it be so difficult for them to make glucose exchange and to estimate bulk? Estimates are not advisable, of course. Actual weights are preferable.

Diabetic patients seem to have an outlook peculiar to themselves. When they occupy the same sun parlors, sitting rooms and laboratories they help each other by discussing their problems and making all kinds of comparisons.

No. 6—Christmas Salad

By Arnold Shircliffe*



Large Pear (canned)
Cream Cheese
Rubyettes or Raspberries

Green Pepper
Lettuce

ON A BASE of lettuce, place a half pear, which has been trimmed round and a hole cut in center. Pipe cream cheese around border of pear, and alternate diamond shaped pieces of green pepper and halved rubyettes on cheese. Fill center hole with cheese on which place a cross cut from green pepper. Serve cold with Lorenzo dressing.

Lorenzo Dressing—To one pint of good French dressing, emulsified, add one cup chopped water cress and three to four tablespoons Chili sauce.

An attractive Christmas picture is made by this salad which is tasty and satisfying.

*Author of Edgewater Beach Salad Book.

Raw Food Cost

The nutrition department at New York Hospital, New York City, served 1,542,602 meals during the year 1933, or 4,226 per day, according to the hospital's annual report. The cost of the raw food averaged 17.2 cents per meal. The cost was 14 per cent higher during the last six months of the year. The nutrition department instructs pupil nurses in dietetics and advises and instructs patients referred to the nutrition clinic of the outpatient department where 6,890 patients were instructed during the year.



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December Breakfast and Supper Menus*

By WINIFRED HOWARD ERICKSON

Director of Dietetics, Ancker Hospital, St. Paul, Minn.

BREAKFAST

SUPPER

Day	Fruit	Main Dish	Soup or Cocktail	Main Dish	Potatoes or Substitute	Salad or Vegetable	Dessert
1.	Grapefruit (half)	Bacon	Cream of Tomato	Cheese Soufflé	Chips	Head Lettuce, Thousand Island Dressing	Pineapple Sauce
2.	Dates	Scrambled Eggs	Oyster Stew	Assorted Cold Meats	Spaghetti and Tomatoes	Bread and Butter Pickles	Strawberry Sauce
3.	Orange (half)	French Toast, Jam	Cream of Celery	Broiled Bacon	Puff	Green Olives	Pear-Nut Salad
4.	Stewed Prunes	Soft Cooked Eggs		Chow Mein, Noodles (fried)	Boiled Rice	Fruit Salad	Applesauce Cake
5.	Bananas	Dry Cereals	Cream of Potato	Sandwich Plate		Buttered Peas and Diced Carrots	Lemon Soufflé, Whipped Cream
6.	Pineapple Juice	Broiled Ham	Tomato Juice	Creamed Chicken, Home Made Patty Shells		String Bean Salad With Pimiento	Royal Anne Cherry Sauce
7.	Grapefruit (half)	Soft Cooked Eggs	Cream of Spinach	Fried Oysters	Baked	Coleslaw	Jelly Roll
8.	Stewed Figs	Fried Eggs	Clear Tomato	Goulash	Shoe String	Pickled Beets	Applesauce and Ginger Bread
9.	Sliced Oranges	Dry Cereals	Consommé	Barbecued Pork Loin	Glazed Sweet	Waldorf Salad	Cranberry Sauce
10.	Stewed Apricots and Raisins	Bacon	Cream of Mushroom	Jelly Omelet	Parker House Rolls	Mixed Vegetable Salad	Red Cherry Sauce
11.	Orange Marmalade	Scrambled Eggs	Beef Broth	Creamed Sweetbreads	Toast Points	Buttered Peas, Celery Hearts	Fresh Fruit
12.	Grapefruit Sections	Soft Cooked Eggs	Cream of Asparagus	Jellied Chicken	Creamed Parsley	Sliced Orange Salad	Filled Cookies
13.	Stewed Prunes	Bacon	Chicken	American Chop Suey	Baked Squash	Head Lettuce, Russian Dressing	Cream Puffs
14.	Bananas	Dry Cereals		Tomato Welsh Rabbit on Crackers	Baked	Kidney Bean Salad	Fruit Gelatin
15.	Fresh Applesauce	Soft Cooked Eggs		Lamb Chops	Spinach Soufflé	Gelatin Salad With Sweet Pickles, Olives and Almonds	Butterscotch Rolls, Plum Sauce
16.	Fresh Grapes	Doughnuts	Oyster Stew	Cold Sliced Meats	Potato Salad	Stewed Tomatoes	Lady Baltimore Cake
17.	Tomato Juice	Scrambled Eggs		Creamed Chip Beef	Mashed	Beet and Celery Salad	Pear Sauce
18.	Stewed Peaches	Bacon		Escalloped Potatoes and Ham		Pineapple-Cheese Ball Salad	Whipped Gelatin, Whipped Cream and Cookies
19.	Orange and Grapefruit Sections	Fried Cornmeal Mush, Syrup		Creamed Codfish	Baked	Vegetable Salad	Raspberry Sauce
20.	Stewed Prunes and Apricots	Soft Cooked Eggs		Broiled Liver and Bacon	Cornbread	Shredded Lettuce, Celery and Olive Salad	Grape Sauce
21.	Jelly	Fried Eggs	Spiced Tomato Bouillon	Tuna Fish Salad	Escalloped	Stewed Tomatoes, Pickles	Chocolate Roll
22.	Grapefruit (half)	Doughnuts, Jam		Creamed Eggs	Toast Points	Carrot Patties	Fruit Cup
23.	Sliced Pineapple Sauce	Broiled Ham	Cream of Potato	Spanish Rice		Fruit Salad	German Cheese Cake
24.	Fresh Applesauce	Soft Cooked Eggs	Bouillon	Cold Cuts or Creamed Salmon and Peas	Potato Patties With Parsley	Cottage Cheese in Pimiento Cups	Peppermint Ice Cream, Norwegian Cookies
25.	Orange "Santa"	Omelet	Cream of Asparagus	Cold Sliced Ham	Glazed Sweet	Celery Hearts	Fresh Fruit, Sponge Cake
26.	Bananas	Dry Cereals	Barley Broth	Broiled Steak	Stuffed	Sweet Pickles	Peach Sauce
27.	Orange (half)	Bacon	Cream of Celery	Sandwich Plate		Pickled Pears	Chocolate Ice Box Cake
28.	Stewed Prunes	Fried Eggs	Clam Chowder	Deviled Eggs	Puff	Spinach, Sliced Lemon	Blueberry Cobbler, Hard Sauce
29.	Fruit Cup	Dry Cereals	Vegetable	Ham Croquettes		Pear-Nut Salad	Norwegian Prune Cake, Frosted
30.	Grapefruit (half)	Scrambled Eggs and Bacon		Fried Oysters	French Fried	Perfection Salad	Strawberry Sauce
31.	Baked Apples	Sausages	Cream of Pea	Sliced Cheese	Rice Croquettes	Apple and Celery Salad	Apricot Whip

*Space limitations forbid mention of breakfast cereal, bread and beverage. Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.

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SMALL need these days to sell the advantages of individual paper towels. Yet many a hospital staff is trying to be cheerful about towels that not only are unpleasant in texture but short-change the user in drying qualities as well. Other hospitals have installed A.P.W. Onliwon Towels and have found out how satisfactory paper towels really can be.

They are satisfactory for so many reasons that they are used in more hospitals and institutions than any others on the market. For one thing, they are soft and pleasant, yet tough enough not to tear easily when handled with wet hands. They come from their Onliwon Cabinets double-folded, and are so absorbent that one usually does the work of several ordinary towels. Onliwon Cabinets are simple to load and to use, yet protect their contents completely from dirt and handling.

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adds variety to the prescribed diet*

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NEWS OF THE MONTH

Advisers to Economic Security Committee Discuss Medical Care, Health Insurance

Early last summer President Roosevelt appointed Secretaries Perkins, Morgenthau, Cummings and Wallace of his Cabinet, and Harry L. Hopkins, federal relief administrator, as a Committee on Economic Security to study the risks and losses which threaten the security of the individual because of unemployment, old age and sickness, and to recommend to him such policies or legislation as they thought needed.

A general advisory council has been appointed by this committee, including employers, employees and social workers, to help on the general economic phases of these problems. In the phases concerned with sickness four advisory groups have been set up of physicians, dentists, hospital administrators and public health officials to represent their respective fields.

Membership of Hospital Committee

Following the general conference called by the Committee on Economic Security on November 14, at which the President addressed a group of invited delegates, a number of public meetings were held, and each of the four advisory bodies met in an executive session. The membership of the hospital advisory committee is as follows: Arthur C. Bachmeyer, R. C. Buerki, Michael M. Davis, Nathaniel W. Faxon, J. Rollin French, S. S. Goldwater, C. C. Jarrell, Robert Jolly, W. S. Rankin, Alphonse M. Schwitalla, Winford H. Smith, Frederic A. Washburn.

The hospital world will also be interested in the membership of the medical advisory board, which includes the following physicians: Walter L. Bierring, Des Moines, Iowa; Rexwald Brown, Santa Barbara, Calif.; James D. Bruce, Ann Arbor, Mich.; George W. Crile, Cleveland; Harvey Cushing, New Haven, Conn.; Robert B. Greenough, Boston; J. Shelton Horsley, Richmond, Va.; James Alexander Miller, New York City; Thomas Parran, Jr., Albany, N. Y.; George M. Piersol, Philadelphia, and S. R. Roberts, Atlanta, Ga.

The Committee on Economic Security appointed several months ago a

technical staff, of which Edwin E. Witte, professor of economics, University of Wisconsin, is executive director. Edgar Sydenstricker is in charge of that portion of the studies dealing with the risks and losses of sickness. I. S. Falk is his associate on the staff and Nathan Sinai, Michael M. Davis and W. Frank Walker are serving as consultant staff members associated with the dental, hospital and public health phases of the studies. Dr. R. G. Leland and A. M. Simons of the bureau of medical economics, of the American Medical Association met with the medical advisory board and have been invited to participate with the technical staff in various phases of its future work.

The subjects of public health, medical and hospital care supported by taxes and health insurance were discussed at the meetings of the advisory committees. Public statements of the discussions and action which took place were not made, since these groups must first report to President Roosevelt's Committee on Economic Security.

Committee to Meet Again Soon

It is understood that the technical staff presented to these committees a body of facts and tentative proposals on the three subjects above mentioned, (1) the extension and improvement of public health services; (2) of tax supported medical care and hospital service for dependents and other population groups affected with certain diseases and (3) health insurance against illness.

Health insurance was fully discussed from the point of view of considering the details of a plan suitable to the varied needs of the American people and to the interests of the professions and agencies concerned with providing medical care, in the event that legislation on this subject is proposed by the administration.

The committees requested that the time originally allowed for their study and discussions be extended and it is anticipated that they will be called together again within the next two months.

United Hospital Fund Organized in Los Angeles

The United Hospital Fund of Los Angeles was officially incorporated recently as a nonprofit organization under the laws of California.

The purpose of the organization is stated in the articles of incorporation as follows: "That it is a nonprofit corporation, organized solely for general charitable and eleemosynary purposes under Section 606 of the Civil Code of the State of California, and particularly to aid in the charitable work of the hospitals of Los Angeles represented herein, to assist them in obtaining benevolent gifts, by public solicitation and otherwise, and to coordinate and extend their charitable work."

Representatives of the following hospitals in Los Angeles are included among the incorporators of the new organization: California Hospital, French Hospital, Golden State Hospital, Hollywood-Clara Barton Memorial Hospital, Hospital of the Good Samaritan, Methodist Hospital of Southern California, Queen of Angels Hospital, St. Vincent's Hospital and White Memorial Hospital.

The incorporators are John G. Mott, R. E. Heerman, Kenneth E. Grant, Leonard K. Brown, C. J. Elsasser, Lillian Tracey, R. W. Hines, Dr. L. B. Rogers, Dr. Charles A. Warmer, V. L. Andrews, Yvonne Clos, W. Cushman, Enoch A. Morrison, Louis F. Labarere, Mary K. West, Raymond Brennan, Sister Alberta Savage, Sister Vincentine Hurley, Sister M. Irene Renier, Sister M. Susanna Welch, Sister M. Anselma Weber, Ralph J. Thompson, Ralph G. Walker, G. H. Curtis, Rev. Paul G. Elliott, Rev. Thomas O'Dwyer, Sister Mary Ann Keating and Dr. Harry H. Wilson.

Patient Census Increases

Increasing patient census at Berkeley General Hospital, Berkeley, Calif., has made it necessary to reopen the east wing of the hospital to patients. The nursing staff has occupied the east wing of the hospital since the decline in patient census made it advisable from an economy standpoint to close the nurses' home, which is at the rear of the hospital. The nursing staff is again occupying the building.

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NEWS OF THE MONTH

29 States Report Successful Organization of Medical Aid Systems Under FERA

By ALDEN B. MILLS
Managing Editor, The MODERN HOSPITAL

The first comprehensive report on the medical care of the indigent under FERA Rules No. 7 clearly indicates that this program leaves many gaps and fails to provide adequate medical service to many people.

The report, which was made by the American Public Welfare Association under a grant from the Julius Rosenwald Fund, points out, however, that probably the medical care now being received by those on relief rolls is superior to the care that was provided before the federal government began to pay in part for it.

Twenty-nine of the forty-eight states surveyed by the association report a "successful" organization of their medical aid systems under FERA. This does not mean that all relations are serene in these states or that all of the pressing medical problems of the relief clients are being solved. It does mean that the amount of service rendered, the relationships established and the experience gained are "all reasons for congratulation," according to the report.

The major problem, apparently in every area is lack of adequate funds. Other pressing problems still needing solution, according to the report, are: insufficient facilities and trained personnel in some areas and inability to use existing facilities in others, need for medical advice and coordination from FERA, need for effective local supervision of medical work and control of costs, lack of adequate data on extent and cost of programs, lack of hospitalization, need to utilize local clinics and other agencies, to adjust relations with medical professions and to correlate with public health services, lack of care for chronic illnesses and of provision of special services.

In connection with the lack of hospitalization the report points out the difficulties that have arisen. "Because the regulations pay the physician for care done in the home or office but not for care in the hospital or clinic, they weigh the scales unfairly and may force him in some cases to decide be-

tween his financial interests and his professional judgment. Home deliveries are paid for, hospital deliveries are not.

"Hospitalization is an essential part of any medical program which would provide the sick with truly modern care," the report states. It points out that while some cities and a few entire states have had sufficient hospitals and funds to provide hospital care for those who need it and are unable to pay, the majority of states and cities have lacked funds or hospitals or both. Public hospitals are overcrowded. The results are set forth in the report by quotations from letters: "The director of our hospital says that we are receiving more and more patients whose care has been delayed so long that nothing can be done for them." "In my territory we use the Hospital, which is insufficiently manned and not adequate for the care of local patients and when rural patients arrive they either sleep on the floor or two in a bed until a bed is vacant."

In communities where state or local funds were sufficient, hospitalization has been possible in accordance with the spirit of the act, the report states, in government hospitals or voluntary hospitals.

In commenting on the report, Dr. Bert W. Caldwell, secretary of the American Hospital Association, declared that "all that should be done for the care of the sick is not being accomplished." He pointed to the large number of voluntary hospitals which are so distributed as to be convenient to the great mass of the population.

"With these hospitals as the centers of supervisory function," he said, "and with a well thought-out and cooperative working arrangement with the different political divisions of government, welfare relief agencies, philanthropic organizations, and county and state medical organizations, it would be a simple matter to see that practically every patient who is ill and needs care had such care provided."

Connecticut Hospital People Meet in Hartford

At a meeting of the Connecticut Hospital Association held at Hartford Hospital, Hartford, November 23, the association's council on nursing recommended that the association go on record as approving the closing of the schools of nursing in all hospitals in Connecticut which have a daily average of less than seventy-five patients. The association accepted and approved this recommendation.

The care of mental cases in the general hospital and tuberculous patients in the general hospital are two subjects of wide interest that were included on the program at this meeting. These were discussed respectively by Dr. R. L. Leak, superintendent, Middletown State Hospital, Middletown, Conn., and Dr. Willard B. Soper, William Wirt Winchester Hospital, West Haven, Conn. Fire hazards and fire prevention in hospitals were outlined by Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., and the meeting closed with a round table conference on hospital standardization problems.

The committee appointed to study extra charges reported that their findings would be printed soon.

The officers of the association were reelected for another year.

Pennsylvania Groups Plan Joint Conference

The Hospital Association of Pennsylvania will hold its fourteenth annual conference in Philadelphia, May 8 to 10, 1935. Headquarters will be at the Bellevue-Stratford Hotel. The Pennsylvania Dietetic Association and the Pennsylvania State Association of Nurse Anesthetists will meet jointly with the hospital association.

An attendance of between 750 and 1,000 persons is anticipated by those in charge of arrangements for the conference. Plans are being made for a large commercial exhibit in connection with the conference.

Charles A. Gill, Episcopal Hospital, Philadelphia, is president of the Hospital Association of Pennsylvania, the executive secretary is J. N. Hatfield, Pennsylvania Hospital, Philadelphia.

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NEWS OF THE MONTH

Doctor Goldwater's Civic Services Lauded

Praise for the civic service of Dr. S. S. Goldwater, commissioner of hospitals, New York City, was recently expressed to Mayor F. H. LaGuardia by a group of hospital executives and directors of welfare organizations and by the New York chapter of the American Institute of Architects.

The hospital group's statement, which was signed by David H. McAlpin Pyle, president of the United Hospital Fund, and twenty-two other executives, declared that "for thirty years Doctor Goldwater has been engaged in hospital administration and planning. His character and professional standing require, among hospital people, no defense."

The architects declared that the city was fortunate to secure the services of Doctor Goldwater and pointed out that he was in 1930 elected an honorary member of the American Institute of Architects as one who has rendered the profession signal and valuable service and has conspicuously upheld its aim.

These expressions of confidence were called forth by an attack on Doctor Goldwater by C. Francis Murphy who claimed that he had accepted fees from the city for architectural services but is not an architect.

Colorado Association Holds Annual Meeting

The annual meeting of the Colorado Hospital Association, held recently at Denver, was successful both from the standpoint of attendance and accomplishments. Actual registration was 131, although the attendance was well over 200.

An outstanding event on the program was the address by Dr. B. B. Jaffa, Denver General Hospital, Denver, whose subject was "What Routine Should Be Followed in Case of Death?" One of the best attended and most interesting features of the meeting was the round table conducted by Frank J. Walter, St. Luke's Hospital, Denver.

At the business meeting, the need was emphasized for state laws to protect hospitals from deadbeats and from unnecessary losses in motor vehicle accident cases. A definite pro-

gram was arranged for bringing these matters to the attention of the state legislature at its next session.

A motion was adopted to the effect that all papers read at the association meetings are the property of the association and permission to publish them must be secured from the association.

Walter G. Christie, superintendent of Presbyterian Hospital, Denver, was named president-elect of the association. William S. McNary, University of Colorado School of Medicine and Hospitals, Denver, was reelected executive secretary. The first vice president is Robert B. Witham, superintendent of Children's Hospital, Denver.

Psychiatrists Plan Program to Help Mankind

A general program to help mankind and particularly children achieve a sane perspective on a world in which values are likely to change overnight was considered by 600 psychiatrists and others interested in mental health at a meeting held November 14 at the Waldorf-Astoria, New York City.

The occasion of the conference was celebrating the twenty-fifth anniversary of the National Committee for Mental Hygiene, sponsor of the meeting. The greatest work accomplished thus far by mental hygienists was defined as impressing upon the layman the fact that mental health is similar to physical well being and has to be treated scientifically.

The number of patients in hospitals for mental diseases has been increasing three times as fast as the general population, with a 100 per cent increase in such cases during the last twenty-five years, it was pointed out at the meeting. The report shows that there were 159,096 patients in state hospitals in 1910, or 173 per 100,000 of the general population, as contrasted with 318,948, or 225 per 100,000, as shown by the latest census.

Among the speakers were: Dr. Arthur H. Ruggles, president, National Committee for Mental Hygiene; Clifford W. Beers, secretary; Dr. Adolf Meyer, professor of psychiatry at Johns Hopkins School of Medicine, Baltimore, and Dr. Jacob Gould Schurman, former president of Cornell University and former ambassador to Germany.

Large Building Project Under Way in England

Appropriate ceremonies were held in Birmingham, England, on October 23 to lay the foundation stone of the new Birmingham Hospitals Centre and to break ground for the new medical buildings of the University of Birmingham, which will adjoin the hospital. The Prince of Wales was the honored guest on the occasion.

The first installment of the project will comprise the nurses' home, the administration block, the power house, the ward blocks and the medical school buildings. All buildings comprising the first installment are to be ready for occupancy at the same time, the tentative opening being set for October, 1937.

The general hospital of the medical center will, when completed contain 740 beds. The beds will be organized in units of 60, each complete in itself with all necessary auxiliary services. Of each sixty beds, thirty will be for women and thirty for men, made up of one ward of sixteen beds, two wards of four beds and three wards of two beds. A separate block of one hundred beds, fifty of them in single rooms, will be provided for persons who do not come within the category of the ordinary patients of a voluntary hospital.

Massachusetts General May Have Psychiatric Division

The Harvard Medical School and the Massachusetts General Hospital, Boston, are undertaking to bring psychiatry into close relation with other branches of medicine, it is stated in the annual report for 1933 of the Rockefeller Foundation, which has just been published.

It is proposed that a thirteen-bed psychiatric division be created at Massachusetts General Hospital, to be staffed by the Harvard Medical School, with Dr. Stanley Cobb, professor of neuropathology, as chief. The staff of the medical school as well as the hospital administration are eager to give greater emphasis to mental phenomena throughout the medical curriculum and to study nervous functions and aberrations in a more intensive and scientific way, the report states.



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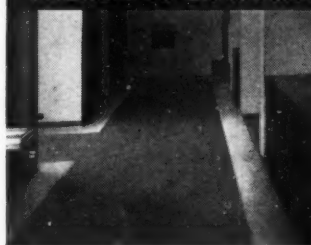
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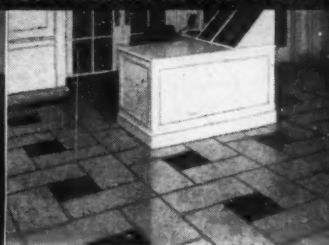
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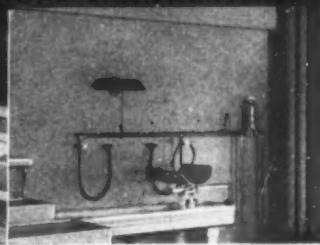
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NEWS OF THE MONTH

Two Associations Will Hold Joint Meeting

The Mid-West Hospital Association and the Missouri State Hospital Association will hold a joint meeting at Colorado Springs, Colo., in June, 1935, the exact date not yet having been determined by the arrangements committee. Headquarters will be at the Broadmoor Hotel.

Frank J. Walter, superintendent of St. Luke's Hospital, Denver, is president of the Mid-West Hospital Association. The president of the Missouri State Hospital Association is Walter J. Grolton, superintendent of City Hospital No. 1, St. Louis.

Ohio Association Adds to Secretarial Staff

Instead of employing a full-time executive secretary as planned the Ohio Hospital Association has decided to employ a full-time assistant executive secretary and has asked A. E. Hardgrove to remain as volunteer executive secretary.

Lucille Brick has been appointed assistant and has opened offices in Columbus. In addition to the work she will do to relieve Mr. Hardgrove, she will also carry much of the detail previously handled by the committee on state relations of which B. W. Stewart is chairman. Mrs. Brick has had extensive experience in various departments of the state government in Columbus.

Rockefeller Foundation Expend \$9,890,806.31

In a detailed report of its activities for 1933 which has just been published, the directors for the different fields describe the work accomplished by the foundation during the year. During 1933 the foundation appropriated \$9,890,806.31 for various philanthropic projects.

The foundation expended for public health work during the year the sum of \$3,286,063.01. In the medical sciences it appropriated during the year \$1,173,853. The foundation's appropriations in the natural sciences amounted to \$807,250. The total amount appropriated for projects in

the social sciences during the year was \$1,636,000. The sum of \$847,500 was appropriated to projects in the humanities, and grants totaling \$589,000 were made by a special trustee committee of the Rockefeller Foundation in support of studies dealing with pressing economic problems in various fields.

College Gets Bequest of 1 1/2 Million Dollars

A bequest of approximately \$1,500,000 has been received by the Long Island College of Medicine, Brooklyn, N. Y., under the will of the late Frank L. Babbott, well known philanthropist of that city.

The principal, to be known as the Frank L. Babbott Endowment Fund, is to be held intact for twenty-five years, the income derived therefrom to be used to further medical education and research. The Long Island College of Medicine, of which Mr. Babbott's son, Dr. Frank L. Babbott, Jr., is president, was incorporated under its present name in 1930. It had been known as the Medical College of the Long Island College Hospital. The Long Island College Hospital was founded in 1858 and was both a college and a hospital under one central control.

Offers Ten-Week Course for Housekeepers

Twenty-five housekeepers have signed up for the course of ten lectures on housekeeping which is being conducted by Doris L. Dungan, housekeeper, Jeanes Hospital, Fox Chase, Philadelphia, and president of the Philadelphia chapter of the National Executive Housekeepers Association at Hahnemann Hospital in that city. Anyone in the hospital or hotel field is eligible. Subjects selected for discussion are: qualities of executives, job analyses schedules, mattresses, blankets, cotton and linen textiles, laundering, rugs and carpets and floor maintenance.

Rhode Island Association Will Meet December 14

The annual meeting of the Hospital Association of Rhode Island will be held at Butler Hospital, Providence, R. I., on December 14. The program will begin at 3 p.m. with an inspection of the hospital. Dinner will be served at 5:30 p.m. and the business meeting will start one hour later. "Future Hospital Financing" is the principal subject on the program for discussion at the organization's business meeting.

Coming Meetings

Hospital Association of Rhode Island.
President, Dr. William O. Rice, Rhode Island Hospital, Providence.
Secretary, Helen M. Blaisdell, Westerly Hospital, Westerly.
Next meeting, Providence, Dec. 14.

National Methodist Hospitals and Homes Association.
President, Rev. Karl Meister, Elyria Home for the Aged, Elyria, Ohio.
Secretary, Guy M. Hanner, Beth-El Hospital, Colorado Springs, Colo.
Next meeting, Chicago, Feb. 13-14, 1935.

Western Hospital Association.
President, Dr. J. Rollin French, Golden State Hospital, Los Angeles.
Secretary, Lola M. Armstrong, *Western Hospital Review*, Los Angeles.
Next meeting, San Francisco, Feb. 18-21, 1935.

Ohio Hospital Association.
President, John R. Mannix, University Hospitals, Cleveland.
Executive secretary, A. E. Hardgrove, City Hospital of Akron, Akron.
Next meeting, Columbus, April 2-4, 1935.

Iowa Hospital Association.
President, Thomas P. Sharpnack, Broadlawn Hospital, Des Moines.
Secretary, Erwin C. Pohlman, University Hospitals, Iowa City.
Next meeting, Iowa City, April 29-30, 1935.

Hospital Association of Pennsylvania.
President, Charles A. Gill, Episcopal Hospital, Philadelphia.
Executive secretary, John N. Hatfield, Pennsylvania Hospital, Philadelphia.
Next meeting, Philadelphia, May 8-10, 1935.

Mississippi Hospital Association.
President, Dr. R. J. Field, Field Memorial Hospital, Centreville.
Secretary, Dr. Leon S. Lippincott, Vicksburg Sanitarium & Crawford Street Hospital, Vicksburg.
Next meeting, Biloxi, May 13, 1935.

Hospital Association of Nova Scotia and Prince Edward Island.
President, Rev. H. G. Wright, Inverness, Nova Scotia.
Secretary, Anne Slattery, Dalhousie University, Halifax, Nova Scotia.
Next meeting, Wolfville, Nova Scotia, June, 1935.

Mid-West Hospital Association.
President, Frank J. Walter, St. Luke's Hospital, Denver.
Executive secretary, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June, 1935.

Missouri State Hospital Association.
President, Walter J. Grolton, City Hospital No. 1, St. Louis.
Next meeting, Colorado Springs, Colo., June, 1935.

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NEWS OF THE MONTH

N. Y. C. Hospitals to Use Standard Formulary

Uniform medicines for every city hospital in New York City are to be provided under a list of about 1,200 medical preparations, drugs, solutions and combinations distributed recently to every hospital ward and dispensary by Dr. S. S. Goldwater, hospital commissioner.

When he took office, Doctor Goldwater said, he found no standard medicine list the same in any city hospital.

In addition to listing the 1,200 preparations, the formulary will contain tables of dosages, explanations as to how solutions should be prepared and directions on how drugs should be administered.

"The adoption and use of a hospital formulary," Doctor Goldwater said, "make for more adequate treatment of patients by the use of standard and well-tried preparations and prescriptions; it facilitates the work of doctors and pharmacists and it is an economy for the city."

Equips Dental Clinic

An important improvement made at Mount Sinai Hospital, Philadelphia, during the last year was the complete installation of modern equipment in the hospital's dental clinic. The new equipment was contributed by the women's auxiliary, in conjunction with Mr. and Mrs. Louis Silverman.

Obstetric Care Is Subject of New Jersey Meeting

Attention of members of the New Jersey Hospital Association was directed to the problems of obstetrics at the autumn round table conference held November 21 at the Holy Name Hospital, Teaneck, N. J. Dr. Walter B. Mount, attending obstetrician, Mountainside Hospital, Montclair, N. J., discussed the prevention and control of impetigo neonatorum. This was followed by a discussion of the subject by Dr. H. D'Agostin, attending obstetrician, Holy Name Hospital, Teaneck, N. J., and Dr. A. V. Brennan, attending dermatologist of the same institution. Supervised obstetrics in

relation to nonstaff physicians was outlined by Dr. Samuel Cosgrove, director, Margaret Hague Maternity Hospital, Jersey City, N. J. This in turn was discussed by Dr. C. H. Knox, chief of obstetrics, Holy Name Hospital, also by Dr. H. B. Wilson, attending obstetrician, Hackensack Hospital, Hackensack, N. J.

Group Insurance Move Shows Large Gain

The families of nearly five million American workers are protected by 8,912 million dollars of group life insurance against the death of their wage earning member, according to a report "Recent Developments in Industrial Group Insurance" published by the National Industrial Conference Board. This insurance is in effect through nearly 30,000 group life insurance contracts now existing, under which employers and employees cooperate to protect the families of the employees against want when the family wage earner dies.

In addition, more than 505,000 employees are protected to the extent of 744 million dollars by group insurance against the liabilities of accidental death and dismemberment. Nearly 1½ million workers are protected against the hazards of sickness and accident to the extent of 16 million dollars in weekly benefits. Nearly 200,000 workers are assured a steady income after they retire through more than 200 group annuity policies, which provide for monthly incomes after retirement aggregating more than 8 million dollars.

According to information received by the conference board from eight leading American life insurance companies, who have sold a substantial proportion of all group insurance now in force, total group sales during 1933 amounted to 344 million dollars of group life insurance; 97 million dollars of group accidental death and dismemberment insurance; nearly 2 million dollars of weekly benefits in group accident and health insurance, and 1.7 million dollars of monthly income in group annuities and pensions.

Sales of group insurance during the first five months of 1934 were higher than for the same months of 1933.

Predicts Heavy Demands on Voluntary Hospitals

There is every indication that the demands upon voluntary hospitals for free care of the sick will be heavier during the coming year than they have been at any time during the depression, David H. McAlpin Pyle, president of the United Hospital Fund of New York, told the board of trustees at a recent meeting.

"Figures just compiled by the Hospital Information and Service Bureau for the past two years indicate the falling off in the use of private and semiprivate accommodations in the voluntary hospitals, and thousands of persons who heretofore were able to pay for all or part of the cost of their care have become ward patients," Mr. Pyle said. "Last year, out of a total of 4,016,424 hospital days of care in the fifty-six voluntary hospitals comprising the United Hospital Fund, 1,586,975, or 41.8 per cent, were free, and in the out-patient department services 45.4 per cent of the services were free."

Hospital Housekeepers Attend Hotel Meeting

Prominent among those attending the women's day program of the nineteenth National Hotel Exposition, New York City, which was held under the auspices of the New York Chapter of the National Executive Housekeepers Association were many housekeepers from hospitals in the city and surrounding territory. Anne Owens of the Sherry-Netherland Hotel and president of the national association introduced the speakers on an interesting program arranged by Grace H. Brigham of the Hotel Biltmore.

Methodist Association Will Meet in Chicago

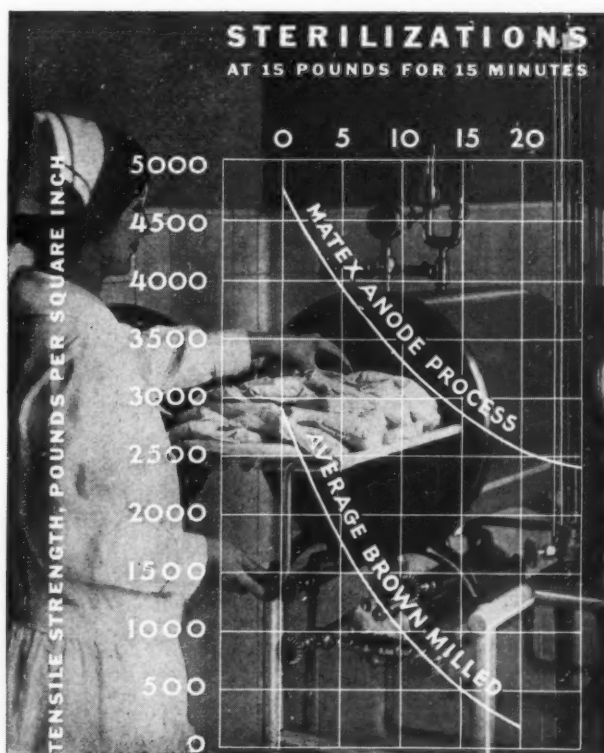
The National Methodist Hospitals and Homes Association will hold its annual meeting for 1935 in Chicago, February 13 to 14. Rev. Karl Meister, Elyria Home for the Aged, Elyria, Ohio, is president of the association. The secretary is Guy M. Hanner, Beth-El Hospital, Colorado Springs.

The REAL FACTS ABOUT GLOVE ECONOMY

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PERSONALS

DR. PAUL KELLER has resigned as executive director of Newark Beth Israel Hospital, Newark, N. J., and is now engaged in the practice of medicine in Newark. In addition to his private practice, Doctor Keller is medical director of the Bankers Indemnity Insurance Company.

WARD WALTZ is the new superintendent of Toledo Contagious Disease Hospital, Toledo, Ohio.

DR. GEORGE L. STIVERS has recently become medical director of the Fall River Tuberculosis Hospital, Fall River, Mass.

DR. ROBERT M. ROSS has been appointed superintendent of Brigham Hall Hospital, Canandaigua, N. Y., succeeding the late DR. HENRY C. BURGESS. Doctor Ross was senior assistant physician at Rockland State Hospital, Orangeburg, N. Y.

ADELIZA AMELIA BETTS, superintendent emeritus of New England Deaconess Hospital, Boston, died on November 11, in her eighty-second year. Miss Betts had been connected with the hospital for forty years, twenty-two of which she was superintendent. For the past twelve years she served as superintendent emeritus.

HILDA WHITEFOOT is now superintendent of Lutheran Deaconess Hospital, Beaver Dam, Wis.

DR. PERCY M. ASHBURN, colonel, U. S. Army, retired, has been appointed superintendent of Columbia Hospital for Women, Washington, D. C.

MRS. WALTER WILLIAMS, wife of the president of the University of Missouri, has donated one hundred volumes to the Mary Jane Lockwood Memorial Library, established recently at the University Hospitals, Columbia, Mo., in honor of her mother.

RUTH WOOD has been appointed superintendent of the school of nursing at Methodist Episcopal Hospital, Brooklyn, N. Y. Miss Wood was formerly superintendent of nurses at Stamford Hospital, Stamford, Conn.

SENA H. BRANDT assumed the superintendency of Blessing Hospital, Quincy, Ill., on November 15, succeeding IRENE FEE, resigned. Miss Brandt

was formerly educational director at Wesley Memorial Hospital, Chicago.

CAROLINE BRICKHOUSE, for a number of years superintendent of Norfolk Protestant Hospital, Norfolk, Va., has been appointed superintendent of Memorial Hospital, Norfolk, succeeding MAY J. HEATH. Miss Heath is assuming the superintendency at Norfolk Protestant Hospital.

JOHN W. FISKE is now superintendent of Northern Westchester Hospital, Mount Kisco, N. Y., succeeding Mrs. L. C. ELMENDORF, who resigned recently after serving as superintendent of the institution for eighteen years. Mr. Fiske was formerly superintendent of Murray Hill Sanitarium, New York City.

DR. LEWIS LINN MCARTHUR, chief surgeon at St. Luke's Hospital, Chicago, since 1886, and for more than forty years one of the outstanding figures in American surgery, died at his home in Chicago on November 6. He was seventy-six years old. Doctor McArthur was also chief consulting surgeon at Michael Reese Hospital and Grant Hospital, Chicago, and Evanston Hospital, Evanston, Ill.

INA M. KINNEY has been appointed superintendent of Gage Hospital, Bell, Calif.

P. CARICO is the new superintendent of Champaign Hospital, Urbana, Ill.

FANNIE BURNHAM has been named superintendent of Henrietta D. Goodall Hospital, Sanford, Me.

SISTER M. PHILOMENA is now superintendent of St. Luke's Hospital, Pittsfield, Mass.

JANE P. LANG has been named superintendent of Harbor Beach Hospital, Harbor Beach, Mich.

ELIZABETH WOOLSEN is the new superintendent of Christian Hospital, St. Louis.

MANDEL R. ABRAHAMS has been appointed superintendent of Ideal Hospital, Endicott, N. Y.

BERTHA GEMBERLING has been appointed superintendent of Fairbury Hospital, Fairbury, Ill., succeeding LUCILLE LEECH, who has served as head of the institution for the past

year. Miss Gemberling was formerly superintendent of Gilman Community Hospital, Gilman, Ill.

DR. J. J. AYO has been appointed superintendent of East Louisiana State Hospital, Jackson, La.

M. R. VELVE has been named superintendent of the State School for Dependent and Neglected Children, Owatonna, Minn., succeeding the late G. A. MERRILL. Mr. Velve was formerly head of the Minnesota School for the Blind, Faribault, Minn.

IVY LEE, director of public relations for many of the nation's large industrial corporations, and who for many years donated his services to the United Hospital Fund of New York, died on November 9.

LUCY M. MOORE, for twenty-five years superintendent of Knickerbocker Hospital, New York City, died at the hospital on November 8 after an illness of several weeks. Early in her career, Miss Moore was called to take charge of the Jay Hood Wright Hospital at One Hundred Thirty-First Street and Amsterdam Avenue, New York City. The corporate name was later changed to Knickerbocker Hospital. Under her supervision a new 250-bed structure was erected.

NAN COX HARE has been named superintendent of Berea College Hospital, Berea, Ky., succeeding LORENA HAFER, resigned.

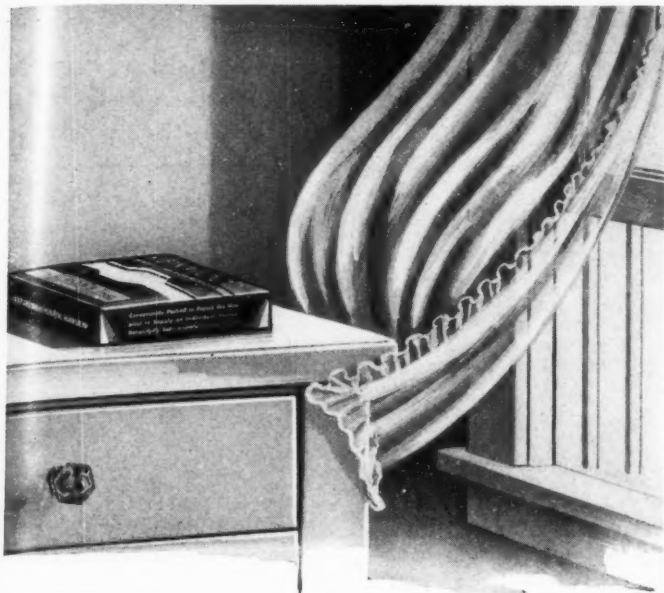
G. R. HARRIS is the new superintendent of Detroit Receiving Hospital, Detroit, and Dr. J. J. Prendergast is director of the professional service.

FLOY G. LOUDENSLAGER has been appointed superintendent of R. B. Smith Memorial Hospital, Alma, Mich. Miss Loudenslager was formerly associated for several years with the University Hospital, Ann Arbor, Mich.

F. M. GROGAN, formerly superintendent of State Hospital No. 2, St. Joseph, Mo., has been named superintendent of City Sanitarium, St. Louis.

DR. G. D. JOHNSON is the new superintendent of Spencer State Hospital, Spencer, W. Va.

MARY LIVINGSTON has been named superintendent of Henry and Catherine Hand Hospital, Shenandoah, Iowa.



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NEATNESS is so characteristic of hospitals that disorder is the more notable. It is an unwritten law that preventable disorder is intolerable. That is probably one reason why Kenwood *Folded Kerchiefs* in their neat, attractive, individual boxes have been received so enthusiastically. They are not only protected from contamination, but they won't blow all over. No unsightly pile on the patient's table. No vagrant kerchiefs blown about the room.



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HERE'S NEWS

COLOR IS NOW CONTAGIOUS

A NUMBER of hospitals have caught the bright new idea of using colored uniforms for contagious wards. And have found it has many advantages beyond the added cheerfulness! Colored uniforms are far easier to keep separate for special laundering processes, for one thing.

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BOOKS ON REVIEW

HEALTHY BABIES ARE HAPPY BABIES. By Josephine Hemenway Kenyon. Boston: Little, Brown & Company, 1934. \$1.50.

This is an excellent book for the mother who is well above the poverty line and who has been accustomed to the use of reference books. The average mother or the foreign born mother found by the public health nurse in congested areas would be discouraged by the size of the book as well as by much of the terminology.

In the first chapter, "Before the Baby Comes," many questions in the minds of prospective mothers are clearly answered, from the physical and emotional changes in the mother to the actual items to be prepared for the delivery and postpartum period. There is much practical advice which if used universally would reduce the hospital's occupancy rate. For instance, "If you close a safety pin automatically every time you touch one it will save you anxiety since the baby will not have swallowed *that* one open!" The mother will be interested in checking her baby's progress from the sixth chapter, in which the author says "The baby at four weeks can lift his head," through each succeeding chapter until the achievements of a child of three are outlined.

The subject of posture is particularly well covered. More might be said, however, about refusal to eat, or at least it could have been emphasized in the earlier chapters. This has been developed in the chapter devoted to the child of two and a half, by which time the child's attitude toward food is pretty definitely set.

Diagrams and simple illustrations might have been used to advantage in clarifying detailed descriptions.

Doctor Kenyon advises, most wisely, that the reader consult her physician. The mother whose normal child is under the regular supervision of a competent pediatrician will still need much supplementary help with the many, many details that make the baby healthy and happy. If a marked physical or mental abnormality exists that is an individual problem no handbook can cover. — MABEL W. BINNER.

GOOD COOKING MADE EASY AND ECONOMICAL.

By Marjorie Heseltine and Ula M. Dow. Boston and New York: Houghton Mifflin Company, 1933. Pp. 502. \$2.50.

The title accurately describes the nature of the contents. Buying, preparation, cooking and serving of foods commonly used in this country are discussed, with the easiest and simplest ways of performing each process told in detail. Directions for planning menus, assembling meals and concocting individual dishes are explicit enough to be readily followed. Time and temperatures required for cooking and the number of servings to be obtained from each recipe are given, together with suggestions for varying the dish or serving it in new combinations.

Some of the features not usually found in cook books are — a buying guide giving in tabulated form the practical points to observe in selecting and purchasing the various food materials; a paragraph at the beginning of each chapter advising on garnishing and other items applying specifically to the recipes in that group; a chapter on kitchen equipment and utensils, their care and how to use them intelligently. — LULU G. GRAVES.

THE
PIONEER

A black and white photograph of a pioneer man standing between two oxen. The man is wearing a wide-brimmed hat and a dark coat, holding a long stick. He is standing in front of two large oxen, one of which is white with dark spots. In the background, a covered wagon is visible, with a person sitting inside. The scene is set in a field with a fence in the distance.

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NEWS FROM MANUFACTURERS

"DEXTROSE INTRAVENOUSLY"

The rapidly increasing importance of intravenous glucose therapy makes "Dextrose Intravenously" a timely, valuable book — the more so since it is written by that well known authority, Dr. Bernard Fantus, professor of therapeutics, college of medicine, University of Illinois, and director of therapeutics, Cook County Hospital, Chicago.

The book is published by the American Hospital Supply Corporation, Merchandise Mart, Chicago, in cooperation with Don Baxter Intravenous Products Corporation, Glenview, Ill., and Don Baxter, Incorporated, Glendale, Calif. This book will be sent on request without charge.

There are thirty pages in all, the last fifteen pages consisting of a bibliography. The author's literary style and his clever use of interesting subheads make the book good reading as well as instructive.

Appended to this book is a fourteen-page booklet, "The Prescribing of Dextrose Phlebotomy." Of this Doctor Fantus says in the preface: "Rather than exhaustive and exhausting treatises we need, I believe, vivid mental pictures that will instantly flash into our mind when called upon to master medical or surgical emergencies. May this booklet be of help in this manner."

VALUABLE BOOK ON SURGICAL PROCEDURE

"Operative Procedure" is the title of a valuable book for surgeons and other professional personnel of hospitals which is being distributed in its second edition by Johnson & Johnson, New Brunswick, N. J. The book contains a series of illustrations pointing out not only the most timely surgical technique but likewise the outstanding steps in forty different operative procedures. The illustrations were created by that distinguished artist, Tom Jones, in association with several noted surgeons. The executive office of the American College of Surgeons collaborated in preparation of the material. The Johnson & Johnson line of ligatures and sutures is described in the pages at the back of the book.

MANUFACTURED MILK AND CREAM

A machine for making reconstituted milk and cream using unsalted butter, milk powder and water, or unsalted butter and skimmed milk or whole milk is being offered by J. B. Hayes, Inc., Urbana, Ill. Milk and cream of any desired richness can be prepared. The manufacturer claims that this machine will save 40 per cent on regular cream costs and on ice cream mix costs.

The machine performs four functions, as follows: It pasteurizes raw milk or cream; it homogenizes milk or cream, putting butter fat in suspension; it reassembles component parts of cream, by emulsification, and it homogenizes ice cream mix.

The operation of the Hayes Emulsor is simple. The atomizing jets merely distribute the melted butter fat in minute uniform sized globules throughout the milk serum (reconstituted or normal skimmed milk) and they stay in emulsion just as well or even better than they do in normal milk or cream, it is stated.

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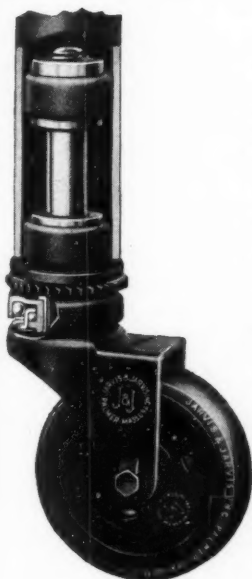
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The rubber-expanding applicator keeps the caster securely in place, and is easily attached and removed. If you haven't seen this remarkable caster, you can have a set on approval. Just specify size, 2", 3", 4", 5", or 6".

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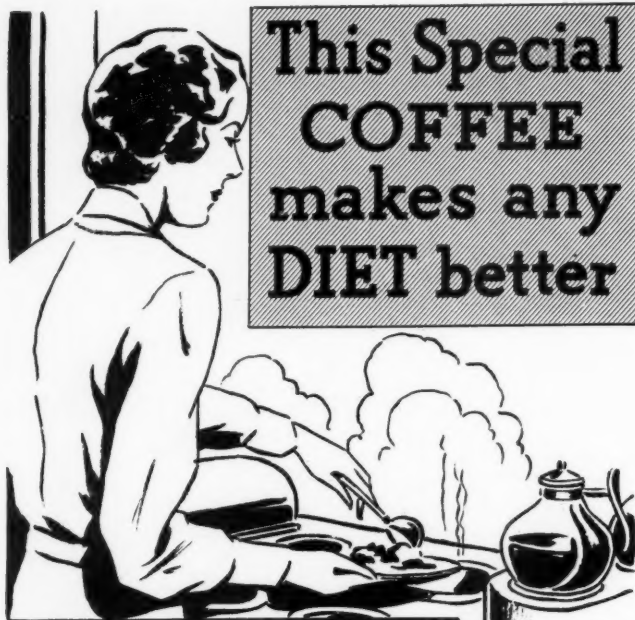
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Hospitals have come to accept as an economical necessity the automatic dishwasher. Now comes its twin brother, the glass washer, to eliminate extra labor, save on hot water expenses, increase sanitation, decrease breakage and, above all, create satisfaction among those using the hospital's food service.

The new glass washer placed on the market by General Electric Co., Cleveland, is sold as an auxiliary to its regular line of dishwashing machines, thus decreasing original costs.

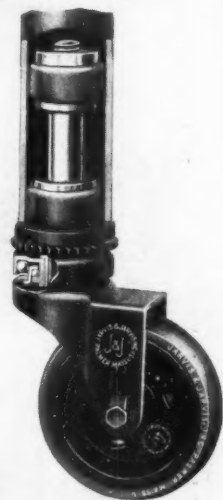
The Model A dishwasher is the unit ordinarily recommended to be used with the glass washer, although any of the sink models will do. The rubber dishwashing trays are merely replaced with a special set of glass washing trays. Combined water action and recognized soaps or detergents will turn out clean glasses without toweling, it is stated. Silver may also be washed in the new device.

AN IMPROVED HOSPITAL CASTER

New principles of design and construction are incorporated in a caster for hospital equipment that has been placed on the market by Jarvis & Jarvis, Inc., 102 South Main Street, Palmer, Mass. The caster is available in different styles and sizes to meet varying requirements.

There is no metal to metal contact with this new caster. The live rubber cushion base, it is stated, not only prevents shock but also seals the end of the leg against entrance of moisture, dust, vermin and germs. The caster is equipped with a bronze axle bearing and easy rolling, clincher grip tires. All rubber, soft tread wheels are available if desired.

The special rubber expanding applicator cushions the wall of the tubing against jolts, the manufacturer states, and will not split, bulge or damage tubular legs. The caster is equipped with a double ball bearing swivel, which facilitates movement of equipment.



COMBINED FAN AND LIGHT FIXTURE

Several new designs and improvements in existing types of the Guthfan, a combination lighting fixture and air circulating fan, have been announced by the manufacturer, Edwin F. Guth Company, St. Louis. The most outstanding improvement is the new method of supporting the motor and lights which, according to the manufacturer, eliminates vibration and lengthens the life of the lamps. Guthfans are now supplied with both one and two-speed motors.

The Guthfan is ordinarily hung from the ceiling in the center of the room. The cooler and drier air from the vicinity of the floor is drawn upward to the revolving blade and forced outward and then downward to the floor, back to the center of the room and then up again to the fan blade.

A portable pedestal type fan is available, either with or without lights. The ceiling type is also available without lights.

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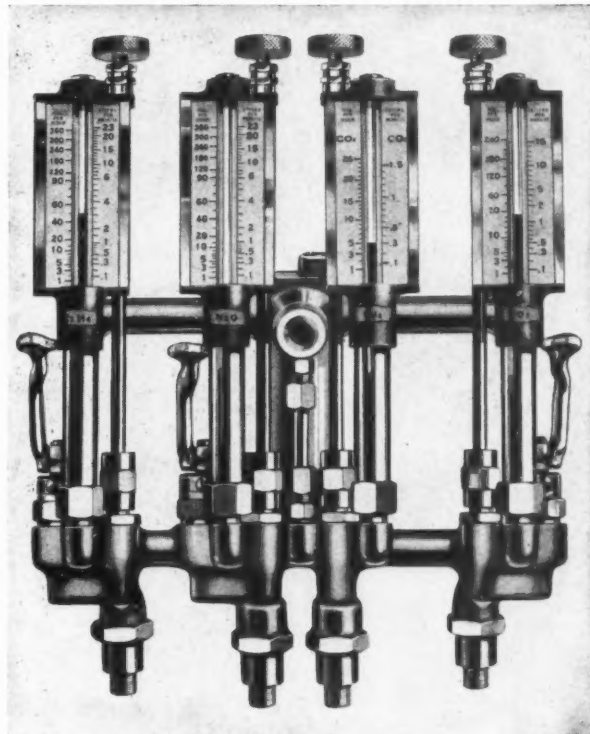
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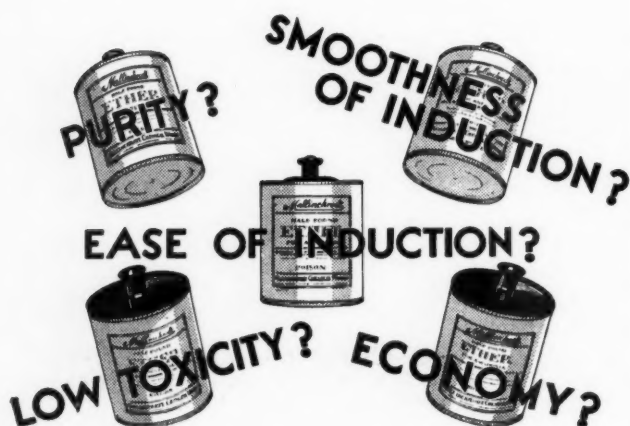
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AIR FILTER TO RELIEVE HAY FEVER

A new electrical appliance, the Milwaukee Air Filter, is being offered as a means of relieving hay fever and pollen asthma. Installed in a few of the patients' rooms in the hospital, such a device should add materially to the comfort of those patients who may be afflicted with hay fever and pollen asthma in addition to the ailment for which they are being hospitalized.

The new device consists of a centrifugal fan driven by a fractional horsepower electric motor and close meshed dry filter element. The entire unit is housed in a green crackle finish nonrusting metal housing and can be connected to any electrical outlet. It is designed to be installed in sleeping room windows of either the conventional slide or casement types. The fan forces the outside air through the filter, giving pollen-free air on the inside. Other windows and doors are closed and the pressure built up forces the exhausted air out under the door and other cracks, making it unnecessary to seal the room. The fan and motor are placed outside the window to provide quiet operation.

The device is approved by the American Medical Association. The product is manufactured by the Perfex Corporation, Milwaukee.

NEW TRADE CATALOGUES AND PAMPHLETS

Libby, McNeill & Libby—A synopsis of the research done on its new line of homogenized foods for babies is contained in a booklet that is being distributed by Libby, McNeill & Libby, Chicago. The company's special homogenization process is applied to fruits, vegetables, soup and cereals. Physicians, pediatricians, dietitians and other members of the hospital professional personnel will find this research of interest.

Wilmot Castle Company—"Castle Lights" is the title of an eight-page pamphlet that is being distributed by Wilmot Castle Co., 1151 University Avenue, Rochester, N. Y., manufacturer of operating lights. The company's major operating unit, its clinical model, minor surgery model and two portable spotlight models are described.

Armstrong Cork Company—New booklets have been released by the floor division of Armstrong Cork Company, Lancaster, Pa. Linowall, a waterproof wall covering material which is offered in twenty different color effects, is one of the products described. Two other booklets contain interesting information regarding the company's line of linoleum, linotile, cork tile, Accotile and various types of rubber tile flooring.

S. Blickman, Inc.—Catalogue R, published recently by S. Blickman, Inc., Weehawken, N. J., covers the company's line of hospital and physicians' equipment. The catalogue contains forty-eight pages.

Detroit-Michigan Stove Company—The Garland division of Detroit-Michigan Stove Company, 6900 Jefferson Avenue, Detroit, has just issued Catalogue No. H-34 showing the company's complete line of gas cooking equipment for hospitals and institutions. Ranges, table ranges, broilers, roasters, deep fat fryers, toasters, hot plates and griddles are shown.

Republic Steel Corporation—Bulletin 125 published by Republic Steel Corporation, Massillon, Ohio, contains up to the minute data on Enduro 18-8 Stainless Steel as well as several of the more important variations which make up the Enduro 18-8 series of types. The booklet contains metallurgical and fabrication data, and a table of laboratory corrosion data.

WHAT THE MODERN HOSPITAL USES!



ONE OF THE MANY DESIGNS OF "COSMO" DESKS



CHARTING EQUIPMENT

PROVIDES A SYSTEM WHICH HAS ELIMINATED THE MANY OBJECTIONS, DIFFICULTIES AND INCONVENIENCES OF THE OLDER METHODS

A Necessity for Every Modern Hospital

WHAT IT HAS ACCOMPLISHED

- Chart records can no longer be scrutinized by the patient or by the inquisitive visitor.—They are accessible only to the nurse and doctor.
- Charts are protected against mutilation or loss.
- Charts are systematically arranged, with positive identification.
- Charts are quickly accessible when wanted, by the visible method.
- Charts need no longer be carried but may be wheeled through the wards when making rounds.

USED BY MANY OF THE LEADING HOSPITALS OF THE COUNTRY



COSMO WALL TYPE CHART RACK
Can be hung on wall or set on table.

These racks are available in all sizes and capacities suitable for setting on or attachment to your own desks or tables.

SEND FOR HOSPITAL HELPS No. 9

MANUFACTURERS

THE HOSPITAL SUPPLY COMPANY

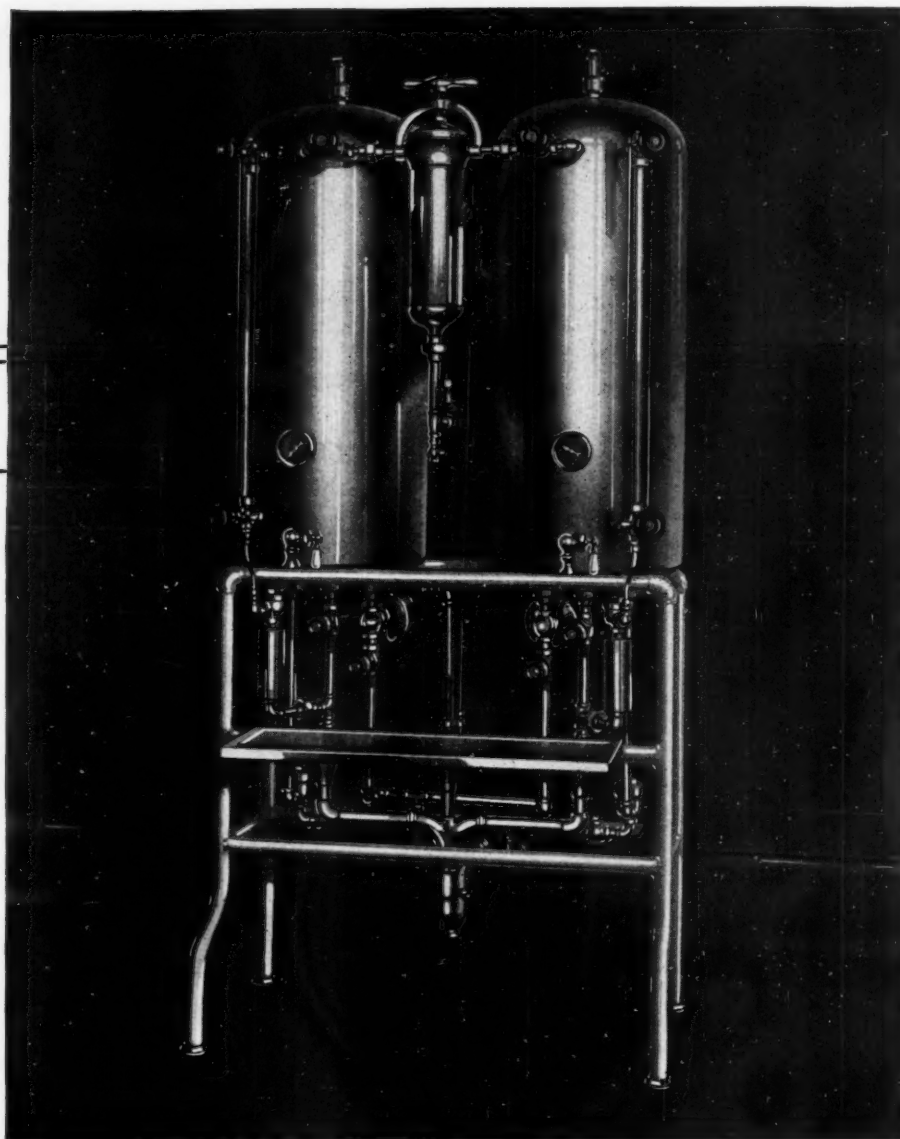
155-7-9 EAST 23rd ST. NEW YORK, N. Y.

Leading Manufacturers of Hospital Equipment Since 1898



"COSMO" CHART CARRIAGE

A visible rack for systematically holding charts. Portable, so that it can be wheeled through wards when making rounds. Made in all capacities.



The new type "White Line" water sterilizers embody features of immense value in hospital work

A410 "WHITE LINE" WATER STERILIZERS

SUBSTANTIAL construction and simplicity of design insures utmost efficiency, safety and convenience in operation and maintenance.

The *full capacity* reservoirs are built of oval headed seamless drawn brass shells fitted with cast bronze bottoms, removable for easy cleaning of reservoir interiors.

Each reservoir is equipped with Magath-Linde combination device for automatically sterilizing water gauge glass during the sterilization process and for filtering air to the reservoir. *Positive in action and completely automatic*, the air filter insures protection of the sterile water supply by admitting only sterile air to the reservoir.

SCANLAN-MORRIS COMPANY

MADISON, WISCONSIN, U. S. A.

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Surgical Lights
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"The White Line"
 HOSPITAL FURNITURE
 STERILIZING APPARATUS

Branches
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Absorb Noise

at its Source with

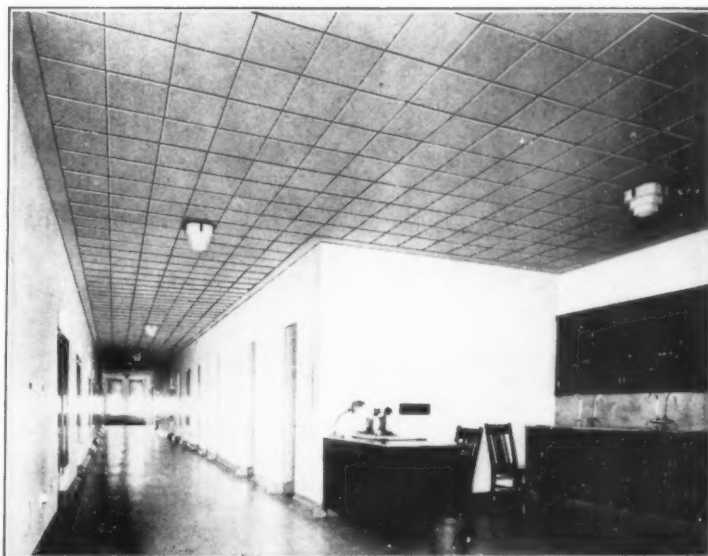
Acousti-Celotex

Most of the disturbing noise arises from normal activities in hospital corridors, kitchens, elevator lobbies, utility and delivery rooms. Acousti-Celotex sound absorbing tiles on the ceilings of these halls and rooms absorb the noise at its SOURCE. Result: The restful quiet so necessary to the well-being and normal recovery of patients.

Positive and practical advantages make Acousti-Celotex the favored prescription to quiet noise. Some of them are:

1. *High Degree of Absorptivity*—One square foot of Triple B absorbs, at 512 cycles, 91% of the incident sound.
2. *Decorative*—Its natural tan color and soft texture make a pleasing interior finish, or it can be painted any desired color.
3. *Paintable*—May be painted or stenciled to harmonize with any architectural design *without loss of sound-absorbing efficiency*, because of patented perforations which provide access for sound waves into the inner absorbent material.
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5. *Economy of Maintenance*—Easy to clean with brush or vacuum. When painted with lead and oil, it may be washed.
6. *Ease of Installation*—Units may be applied directly to existent ceilings—decorated or painted before application, if desired.

Service Available—To meet various requirements Acousti-Celotex offers four types: Type A, Single B, Double B and Triple B with coefficients of .36, .47, .63, .91, respectively. The Acousti-Celotex contracting engineer in your city, or the acoustical engineering staff of The Celotex Company, will gladly furnish you, without



Acousti-Celotex quiets the corridors of the Swedish Hospital, Minneapolis, Minn.—Magney & Tusler, Architects.

obligation, a complete analysis and recommendation as to the treatment needed for the best results; also with a list of hospital installations. Prices are lower now.

• • • • •
• THE CELOTEX COMPANY
• 919 No. Michigan Ave., Chicago, Ill.

M. H. 12-34

• Please send me ☐ the name of the Acousti-Celotex contracting engineer in my city, ☐ technical data.

• Name _____

• Address _____

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ACOUSTI-CELOTEX
TRADE MARK REGISTERED U.S. PATENT OFFICE



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For complete lists of hospital products and sources of supply consult the current Edition of THE HOSPITAL YEARBOOK.



STERISOL Ampoules

(STERILE SOLUTIONS)

*The
Latest
Contribution
to
Intravenous
Therapy*



THIS is the present day method of intravenous therapy. An Ampoule containing sterile solutions of various strengths is now available in heat-retaining Pyrex glass. One end is moulded into a hook of sufficient size for suspension,—the other, or straight end, is drawn out to receive the infusion tubing, making a leak-proof connection. The Sterisol Ampoule thus becomes in reality an integral part of the infusion apparatus. The solution is hermetically sealed in our own laboratories in crystal-clear Pyrex glass Ampoules, and is instantly ready for use. Simply open the sealed tips and attach tubing of infusion apparatus.

Sterisol Ampoules are available in three sizes, 250 cc., 500 cc. and 1000 cc. capacity. A gauge calibrated in centimeters on the side of the Ampoule shows at a glance the amount of liquid being used.

We carry in stock the following Solutions: Dextrose in normal saline or distilled water 5%, 10%, 20% and 25% concentrations. Ringer's Solution, 5% Dextrose and 10% Dextrose in Ringer's Solution. Physiological Sodium Chloride and Sodium Chloride Solutions of 1.2%, 2% and 5% concentrations.

Write, Telephone, or Wire for Literature and Complete Information.

STERISOL AMPOULE CORPORATION
37-02 NORTHERN BLVD., LONG ISLAND CITY, NEW YORK, U.S.A.

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PIONEERS IN MEDICINE AND SURGERY . . . NO. 5



Baron Joseph Lister, Whose Antiseptic System Revolutionized modern surgery

TO BARON JOSEPH LISTER modern surgery owes its foundation. In 1865, convinced that putrefaction was due to microbes coming from the air, he decided that these organisms should be destroyed before contact with wounds. Undiluted carbolic acid was applied to a compound fracture. It soon was found, however, that full-strength carbolic was, due to its caustic property, far from satisfactory . . . Lister then turned his attention to the perfection of a spray that would free the atmosphere from microbes, and years later announced his famous spray of 1-20 water solution of carbolic acid.

Lister's ligature technique and his aseptic treatment later were adopted by surgeons all over Continental Europe, for they banished those pestilential surgical menaces, septicaemia, hospital gangrene, erysipelas, and pyaemia.



Anatomically correct shape, its non-slip "frosted" surface yields like natural skin to the flexing of fingers. Greatest sterilization resistance — long-serving.

"And Yet, Betterment is Possible!"

THERE IS no cessation of endeavor in medical science in reaching newer achievement. Always there are wider frontiers to be established. . . . Sensing the demands of this struggle for advancement, Miller laboratories constantly keep abreast of the requirements of modern medical science.

For over a generation Miller has maintained the world's most extensive research laboratories for anticipating the major rubber requirements of the medi-

cal profession. These years of vigilance, of discovery and production perfection have earned national preeminence among the medical profession for Miller surgeons' gloves and aprons; ice caps; throat bags; invalid cushions, and many kindred accessories. Only close, determined cooperation with the medical profession by the great Miller laboratories could so unerringly anticipate the medical world's progress, fully realizing that betterment always is possible.

♣ MILLER RUBBER COMPANY, INC., AKRON, OHIO

Miller

FUEL BUDGET CUT BY MODERNIZATION IN ASBURY HOSPITAL

Webster Moderator Control
Reduces Oil Consumption
35.3 P. C. First Year

DEFIES NORTHERN WINTER

Installation Recovers 1/3 of
Cost in First Season
After Modernization

GIVES IMPROVED SERVICE

Minneapolis.—“As a result of the systematic reduction of hospital overhead during the past few years, many hospitals have found that definite and permanent savings lie in heating modernization,” George K. Belden, Assistant Treasurer of the Asbury Hospital, here, averred recently.

“We have discovered, to our satisfaction, that the severity of Minnesota winters was not the explanation for our oversize fuel bills. We reduced this supposedly ‘fixed’ expense \$1,557.25 during the first season after heating modernization.”

Asbury Hospital is operated by the Methodist Episcopal Church. The main building and the Deaconess building, both heated by oil burner, have a total of 16,000 square feet of installed direct radiation.

“After studying our oil consumption record over a period of years, we decided that economies were possible,” Mr. Belden said. “Determined to be judicious in launching a modernization program, we asked Warren Webster & Company to survey the heating installation and report on the possibility of savings.”

At the completion of their survey, Webster engineers estimated that installation of Webster Moderator Control would reduce the fuel bill substantially and would pay for itself in a very few years. Modernization was authorized and completed by November 1st, with Belden-Porter Company acting as modernization heating contractors.

“Oil consumption for the ‘32-33 season,” points out Mr. Belden, “totaled 105,095 gallons, dropping from 136,240 gallons, used during a previous heating season with comparable degree days—a reduction of 35.3 per cent.

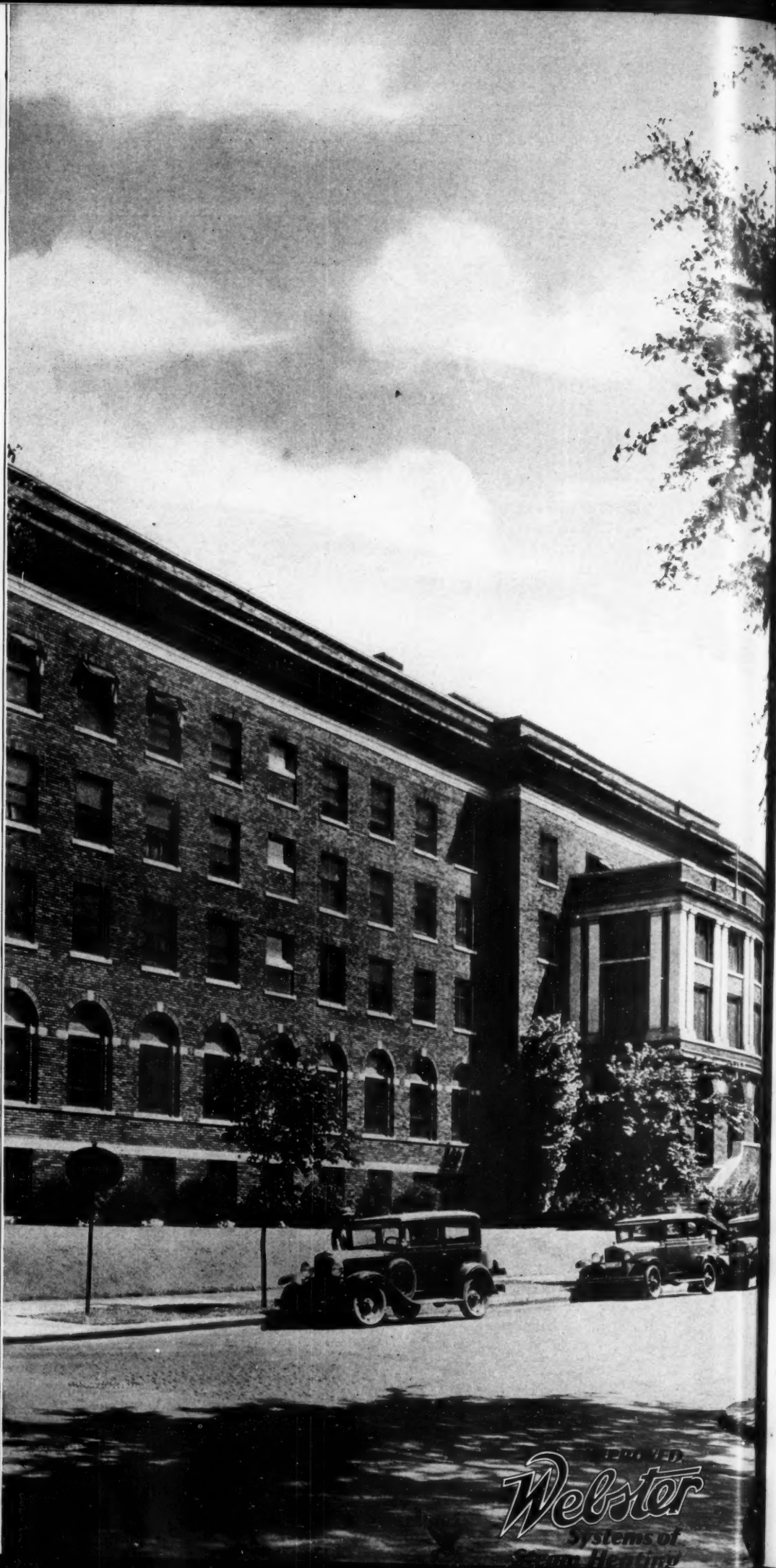
“Figuring oil at five cents a gallon, we had saved \$1,557.25. Since our total modernization cost was only \$4,700 we had liquidated approximately one-third of our investment during the first heating season.

“To hospital executives perplexed with financial worries, the possibility of taking such a huge slice out of the annual operating budget makes a very realistic appeal. And rare is the institution in which all reasonable economies have been effected.

“Asbury Hospital today is receiving better heating service at lower cost. And, according to Webster records, our experience is not unique.”

If you are interested in (1) improved heating service and (2) lower heating cost in your building, address

WARREN WEBSTER & CO., Camden, N. J.
Pioneers of the Vacuum System of Steam Heating



IMPROVED
Webster
Systems of
Steam Heating



HERE is all that you need to know about the treatment of Expensitis—that insidious ailment which strikes the linen room, and whose symptoms are a general breakdown of towel tissue and a consequent inflammation of the budget. *These* are the signs.

The treatment, briefly, can be summed up in two words (even more briefly, in one famous name)—*Cannon towels!* Remove the weak tissue; replace with Cannon towels!

Here's why. Cannons are made of longer, stronger cotton. They're woven sturdily. They're more absorbent, and they come from constant laundering and sterilization showing *less wear*. (Much less!)

What's more, Cannon towels cost less—or come in *better* grades at the price you're now paying. See your jobber for further facts, and for convincing samples! . . . Cannon Mills, Inc., 70 Worth Street, New York City.

Cannon Towels



DESIGNED FOR
Precision
 ACCEPTED FOR
 ESTABLISHED MERIT



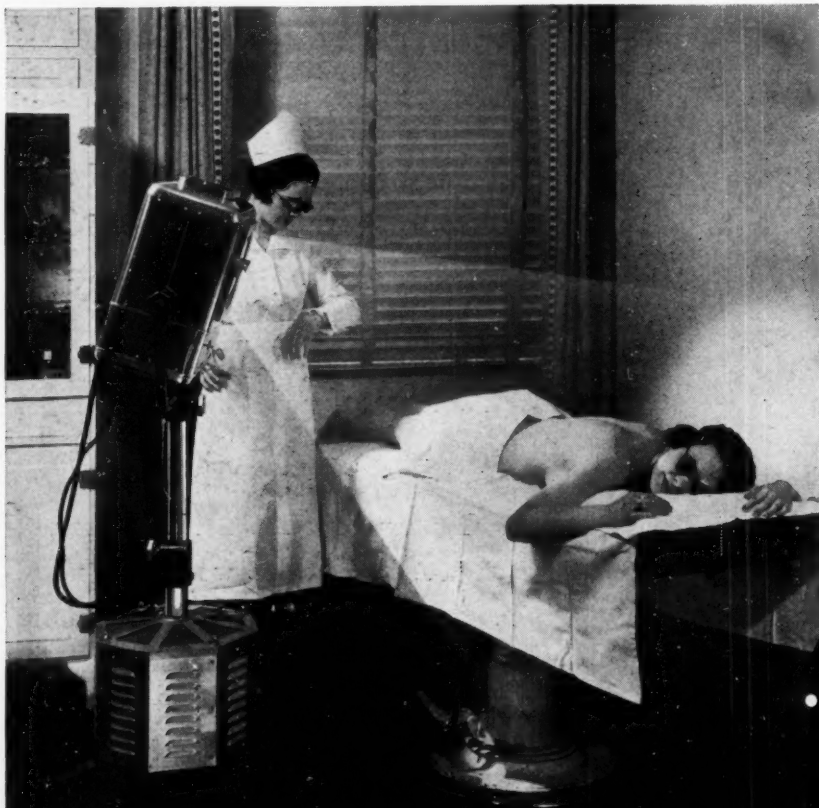
EVEREADY Carbon Arc Solarium Units and Eveready Professional Model Carbon Arc Lamps have been designed to meet the demands of the Medical Profession for precision in artificial light therapy.

Uniform intensity of radiation and steady burning are maintained by mo-

tor driven, constant current arc control.

Removable filter panels of special, ultra-violet transmitting glass limit radiation substantially to rays found in natural sunlight.

Eveready Sunshine and Therapeutic Carbons provide a choice of five distinct types of therapeutic radiation.



Carbon Arc Solarium Units

Provide radiation equivalent to average clinical sunlight for groups of six to twenty-five patients.

Built with one, two or four arcs per unit. Dual trim with ten hour burning period, remote control and thorough ventilation minimize attention.

Professional Model Carbon Arc Lamp

A powerful, efficient, economical and flexible unit designed to meet the exacting requirements of the medical profession.

**EVEREADY
 CARBON ARC
 UNITS**

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Carbon Sales Division, Cleveland, Ohio

Unit of Union Carbide  and Carbon Corporation

Branch Sales Offices: New York • Pittsburgh • Chicago • San Francisco



Accepted by the Council on Physical Therapy of the American Medical Association and by the American College of Surgeons . . .

Uniformity

AN unvarying standard of snowy whiteness . . . Every piece of laundry as white and clean as every other piece. As alike and dependable as the tees that you use on the golf course. Perchloron does not require costly equipment or technical knowledge.

Because of its disinfecting and deodorizing qualities, it also has many other uses in a hospital . . . and can be used anywhere that it is desirable to employ an efficient disinfectant.

You can depend upon Perchloron for uniformity because Perchloron is stable—it always gives a uniform concentration.

That's why leading hospitals everywhere use Perchloron.

It is an American product, made in the U. S. A.

You know the strength of your bleach at all times with Perchloron. Every can of Perchloron, when prepared in accordance with directions, makes 30 gallons of 1% Sodium Hypochlorite.



EXECUTIVE OFFICES: WIDENER BLDG., PHILADELPHIA, PA.

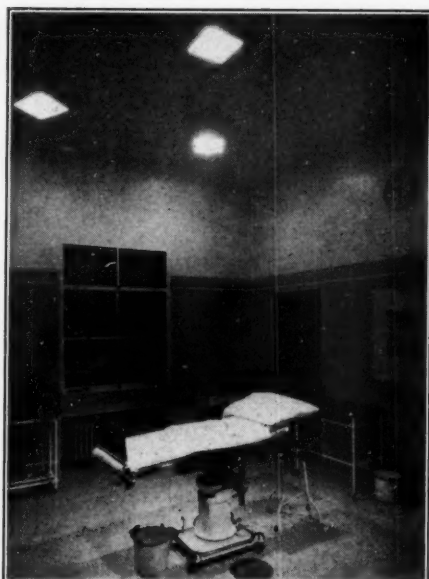
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New York—Chicago—St. Louis—Pittsburgh—Tacoma—Wyandotte



Outstanding Advantages of Holophane Surgery Lighting

High intensity without glare. Protective multiple lamping. Sufficient room brightness. No obstructing equipment. Minimum dust-collecting surface.



Let Holophane engineers help you to light your hospital; not only the surgery, but all other areas—indoor and outdoor—as well.—Address Holophane Company, Inc., 342 Madison Avenue, New York. Offices also in Toronto, Canada. Works, Newark, Ohio.

*Illumination Service
Since 1898*



**HOLOPHANE
PLANNED LIGHTING**
produces the greatest amount of useful light

The Preferred Toast of America!



*PERFECT, uniform,
golden-brown—every
slice the same ALL
the time—with*

the NEW TOASTMASTER

(with Flexible Clock)

... AND AT LESS COST PER SLICE! That's the story in brief! From every angle you can view the matter, it will pay you to use the NEW Toastmaster. Write today for prices and full information. We will include a copy of the valuable little booklet "How to Make and Serve Perfect Toast."

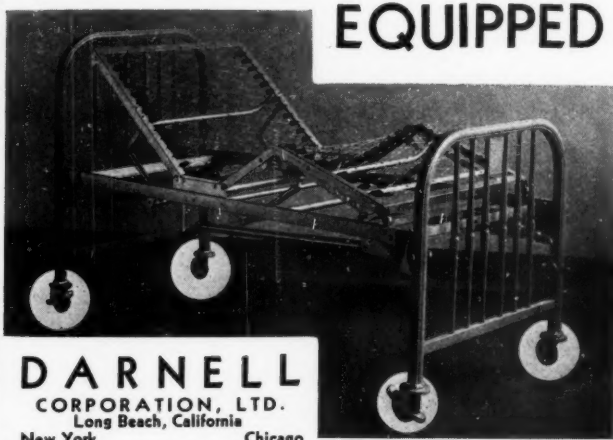
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MINNEAPOLIS, MINNESOTA

A PRODUCT OF MCGRAW ELECTRIC COMPANY

4 Reasons Why Los Angeles County General Hospital

- (1) **EFFICIENCY.** Equipment moves easily, when and where desired.
- (2) **ECONOMY.** Virtually eliminates upkeep expense on casters.
- (3) **PROTECTION.** Prevents wracking of equipment, protects floors.
- (4) **QUIETNESS.** Helps enforce the peace and quiet essential to patient care.

**IS 100%
DARNELL
CASTER
EQUIPPED**



DARNELL
CORPORATION, LTD.
Long Beach, California
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LINCOLN-SCHLUETER

Your Personnel Needs This Efficiency

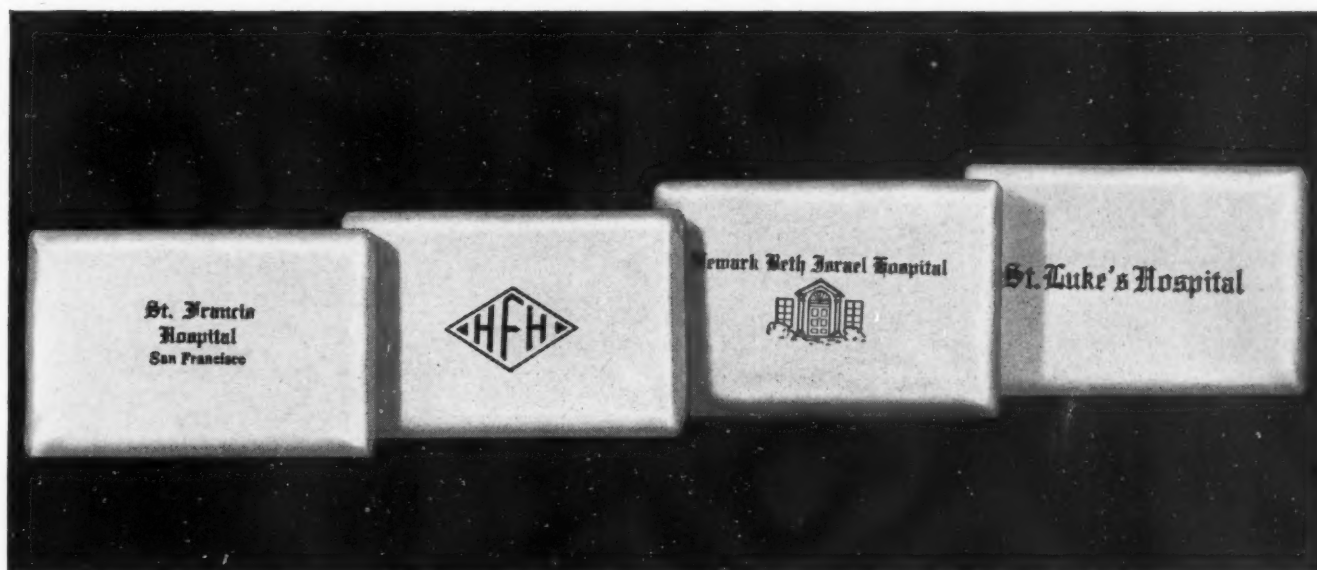
Reduced personnel costs are best when the efficiency of labor is increased. In the maintenance of hospital floors Lincoln-Schlueter Floor Machines offer a new and improved service. (Automatic features—soap and water feed, pick-up machine, etc.)

LINCOLN-SCHLUETER FLOOR MACHINERY CO., INC.
221 W. Grand Ave., Chicago, Illinois

FLOOR MACHINES



Why do America's leading hospitals choose Ivory?



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San Francisco, Cal.

HENRY FORD HOSPITAL
Detroit, Mich.

NEWARK BETH ISRAEL HOSPITAL
Newark, N. J.

ST. LUKE'S HOSPITAL
Denver, Col.

Why do so many outstanding hospitals select Ivory in preference to the many other soaps available for institutional use?

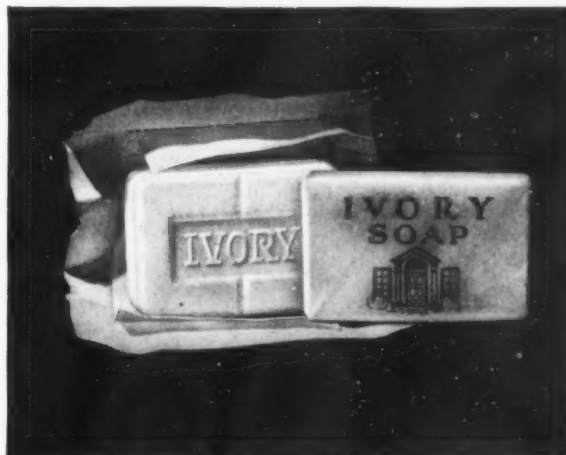
The answer is simple.

To the big majority of America's hospitals, Ivory stands for the ultimate in purity, gentleness, and uniform excellence.

For 55 years Ivory Soap has served the needs of countless hospitals—faithfully, unfalteringly. Throughout these years, Ivory's freedom from causticity and supreme gentleness have contributed much to the comfort of many thousands of fretful, bed-weary patients.

Ivory's 55-year record of service in America's leading hospitals is an enviable one. It will serve *your* institution with equal fidelity.

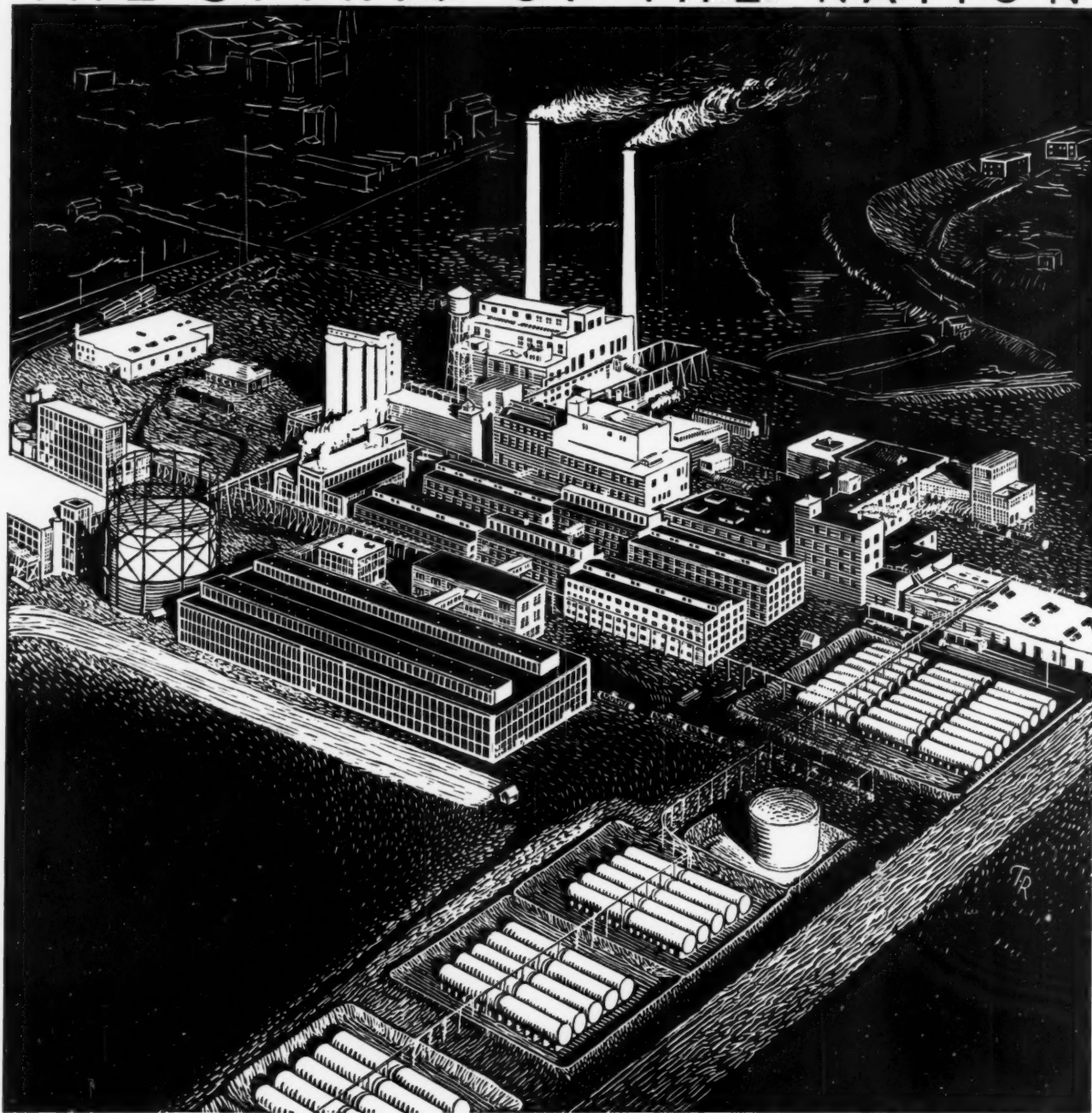
Miniature Ivory Ivory Soap is available for hospital use in a choice of 6 convenient sizes— $\frac{1}{2}$ ounce, $\frac{3}{4}$ ounce, 1 ounce, $1\frac{1}{4}$ ounces, 2 ounces, 3 ounces. Cakes may be had wrapped or unwrapped. The name of your institution will be imprinted free on wrappers with orders for two or more cases.



Procter & Gamble : Cincinnati, Ohio

ROSSVILLE ALCOHOL

THE SPIRIT OF THE NATION



THIS ILLUSTRATION OF ONE OF THE FIVE GREAT PLANTS OF COMMERCIAL SOLVENTS CORPORATION SUGGESTS OUR CAPACITY FOR SERVICE TO YOU.



COMMERCIAL SOLVENTS CORPORATION

DISTILLERS OF FINE ALCOHOL

TERRE HAUTE, INDIANA

BRANCH OFFICES AND WAREHOUSES IN ALL PRINCIPAL CITIES

A CENTURY OF PROGRESS IN LAXATIVES

*"The piercing caustics ply their spiteful power,
Emetics wrench, and keen cathartics scour."*

THUS wrote Dr. Garth of the heroic era in the practice of medicine.

In 1834 cascara was little known, and for the greater part of the ensuing one hundred years its medicinal use was more or less of an heroic nature.

However, years of research in pharmaceutical laboratories have developed a palatable, non-bitter fluid extract of cascara sagrada of full potency.

Now it is ingeniously combined with Petrolagar, the mechanical emulsion of

liquid petrolatum (65% by volume) and agar-agar.

The result is Petrolagar with Cascara (containing 13.2 percent non-bitter fluid extract of cascara sagrada) which stimulates the musculature of the large bowel, at the same time softening the bowel content.

Prescribed with adequate instruction for the formation of Habit Time of bowel movement, it is indeed representative of A Century of Progress in Laxatives.



Petrolagar with Cascara

Merry Xmas

Say it with
**HORNER QUALITY
BLANKETS**



ALL WOOL—INCOMPARABLE in
their lasting quality, with that soft,
luxurious feeling of comfortableness

Write our "Contract Department" for price list



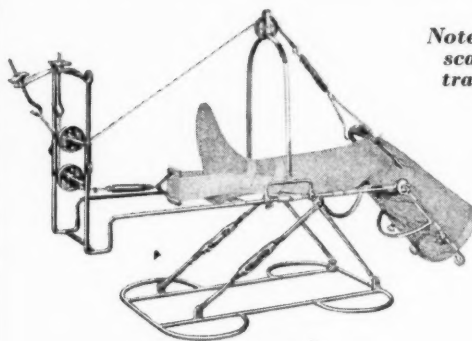
HORNER BROTHERS WOOLEN MILLS

Eaton Rapids, Michigan

Founded 1836

DEPUY

The Name Best Known to Hospitals



Note spring
scale for
traction.

LEITER ROCKING LEG SPLINT

Rests on any bed, may be used for treatment
of femur, lower leg fractures, infections and
gun shot wounds. An excellent appliance for
treating compound fractures.

CHROMIUM PLATED STEEL, \$30⁰⁰
used right or left.....

Fracture book free upon request

DePUY MFG. CO., WARSAW, IND.

FRACTURE APPLIANCES

Cash's WOVEN NAMES

SAVE MONEY— Insure Order and Sanitation

ECONOMY is vitally important these days—
and your linen bills must be kept down.
Lost towels, mislaid sheets, wrongly used linen
mean losses in money, in time, in orderliness,
in sanitation, in good management. That is
why more hospitals are constantly using CASH's
WOVEN NAME-TAPES to mark all linen and the
wearables of nurses, physicians, attendants.
CASH's NAMES identify instantly, prevent loss
or misuse, cut replacement costs. They are the
sanitary, permanent, economical method of
marking. Attached quickly with thread or
CASH'S NO-SO CEMENT (25c tube).
Write and let us figure on your needs—whether
institutional or personal. A folder of styles
and samples with full information will be sent
on request.

Personal Trial Offer: Send 15c for
1 dozen of your own first name
and sample tube of NO-SO Cement

INDIVIDUAL NAME PRICES

3 dozen ... \$1.50	12 dozen ... \$3.00
6 dozen ... 2.00	9 dozen ... 2.50

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Only 1 Bale Out of 17 Measures Up to the Standards Demanded for UTICA Sheets

Utica sheets wear longer because they are
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6% of the cotton crop meets the rigid Utica
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cleanliness. Utica and Mohawk Cotton Mills,
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Utica sheets are approved by the American
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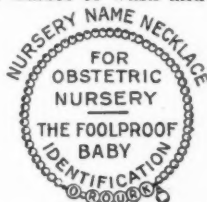


"Don't Forget the Name-On-Beads Necklace"

"This identification necklace is a requirement, nowadays, for a first class stork delivery. The doctors and nurses will see to it that the baby is *delivered safely* . . . and the 'Name-On-Beads' will see that the baby is *kept safely identified*."

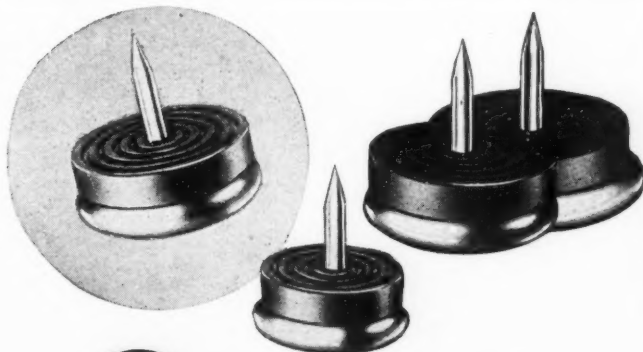
"Babies identified with these Nursery Name Necklaces are easier for the doctors to treat; for nurses to wash and care for. There is no opportunity for a mix-up because the identification is sealed on at birth."

Now, . . . your hospital can purchase the complete N. N. N. baby identification outfit for only \$25.00. Write for full details . . . and sample necklace.



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- ★ Fine Quality Bristles, held in by Special Patented Feature, WON'T COME OUT!
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Sirs: As a Hospital Executive, send me FREE TAKAMINE TOOTHBRUSH.

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Sub-atmospheric steam heating saves so much annually in fuel and steam, that many existing heating plants can be changed-over to Differential operation at no ultimate cost whatever. Change-over work can be done by a heating contractor of your own choosing. Neither boilers, piping nor radiation need to be changed—Modernization costs paid out of savings.

THE DUNHAM DIFFERENTIAL VACUUM HEATING SYSTEM is unique. Steam is circulated at many different pressures—high or low, depending upon the

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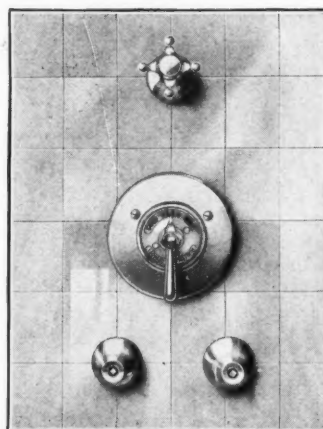
weather—to hold the building steadily at desired temperature. It is a guarantee of controlled healthful heating for patients and hospital

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- The New Series is simple in construction.
- The New Series is accurate and reliable in performance.

We will gladly send descriptive literature upon request; it will be of interest to you.

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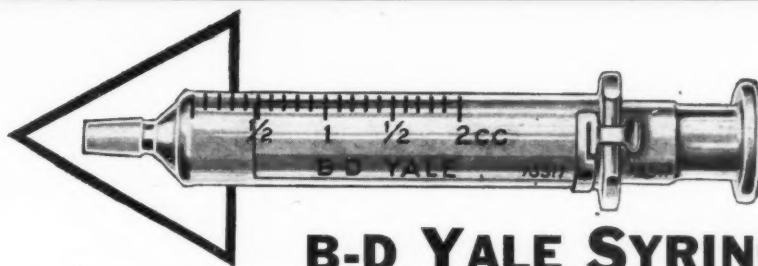
" . . . and now it's up to the sutures. I'm particular about the make I use because suture behavior depends so much on qualities that can't be seen."



D & G Sutures . . . always dependable!

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STRENGTH where STRENGTH is NEEDED



B-D YALE SYRINGES

HOSPITAL Syringe costs decrease as breakage at the tip and barrel base is delayed and reduced.

Hospital Syringe Costs decrease when B-D Yale Syringes are used because they are scientifically designed for strength — where strength is needed, at the tip and barrel base.

The tip, with the grinding run off a shoulder to eliminate a score mark, has the full strength of unground glass. It is the strongest tip ever put on a hypodermic syringe.

B-D PRODUCTS

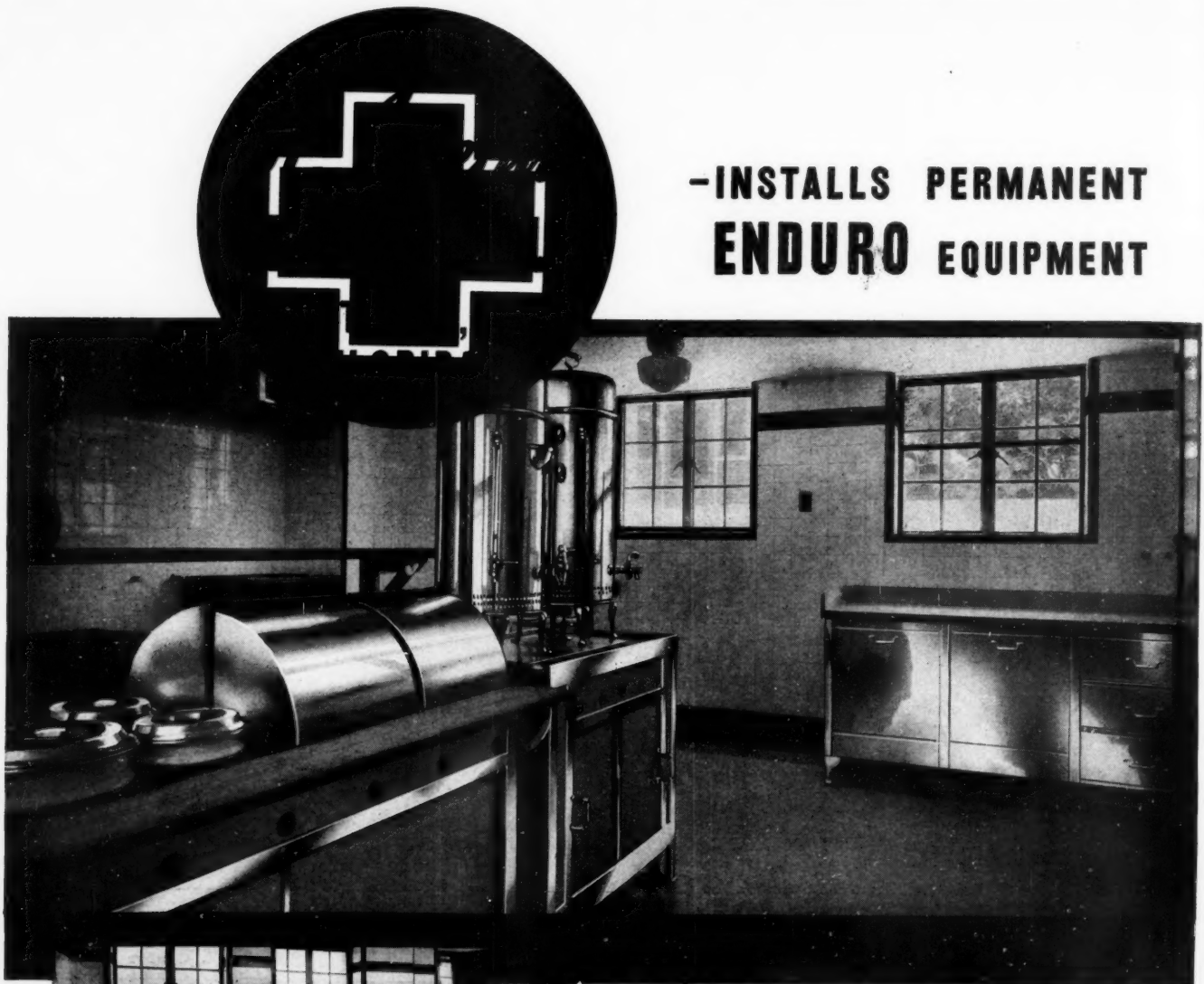
Made for the Profession

The barrel base is flared, to eliminate an internal score mark at the end of the grinding. B-D Yale bases do not pop out at the slightest provocation.

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Yale Syringes deliver the longest period of useful service — which is assurance of sound economy.

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-INSTALLS PERMANENT ENDURO EQUIPMENT



The sinks, steam tables, work tables, drain boards and other equipment in the kitchen of St. Joseph's Hospital, Tampa, Florida, are made from stainless ENDURO. Fabricated by Acme Sheet Metal Works, Tampa, Florida.

Here is some more hospital kitchen equipment *that's in to stay*. It will not have to be discarded and replaced because of rust or corrosion. It will not require constant attention to keep it sanitary and clean. It's made from ENDURO, Republic's perfected stainless steel . . . the permanent

metal. • ENDURO sinks, steam tables, counters and drain boards, like ENDURO cooking utensils, remain safe, sound and serviceable through years of constant service. That's because this improved metal, in addition to being stainless and easy to clean, has strength and toughness far greater than ordinary steel. • Logically, hospital after hospital is adopting ENDURO for all equipment needs . . . in kitchens, clinics, laundries and cafeterias . . . for cooking and serving utensils and for lockers and wash sinks as well. Because when ENDURO's in, it's in to stay. Full data is available. Write Republic today.

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GENERAL OFFICES

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YOUNGSTOWN, OHIO

ARMSTRONG'S Linoleum has definite advantages which make it the *technically correct* floor for hospital purposes. These advantages make it stand out above all other floors.

Armstrong's Linoleum is germicidal. Due to the presence of linoxyn, a gas resulting from the continuous oxidation of linoleum's linseed oil base, germs cannot live on the surface of this floor. Furthermore, this mirror-smooth surface provides no place for dirt and dust to collect.

And Armstrong's Linoleum is economical to keep hospital-clean. Spilled things wash right up with a damp cloth—leave no spots or stains. Maintaining this floor takes but little of the porter's time; uses but little of the board's money.

Important, too, is the fact that

Armstrong's Linoleum Floors are resilient—quiet and comfortable underfoot. They are colorful, creating a cheerful environment which reacts favorably upon patients, aids in their recovery.

QUIET, DURABLE

ECONOMICAL

*.... it meets
every requirement!*



For full information and a list of local floor contractors who will furnish prices, write Armstrong Cork Company, Floor Division, 1210 State Street, Lancaster, Pennsylvania.



Armstrong's LINOLEUM FLOORS

LINOTILE - RUBBER TILE - CORK TILE - ACCOTILE - LINOWALL

A TRULY MODERN HOSPITAL room with a custom-laid floor consisting of Armstrong's Plain Linoleum in black, white, silver gray, and dark gray. Corridors and other rooms in the Myers Hospital, Philippi, W. Va., have similar floors.

HOLTZER-CABOT Equipped

Architect

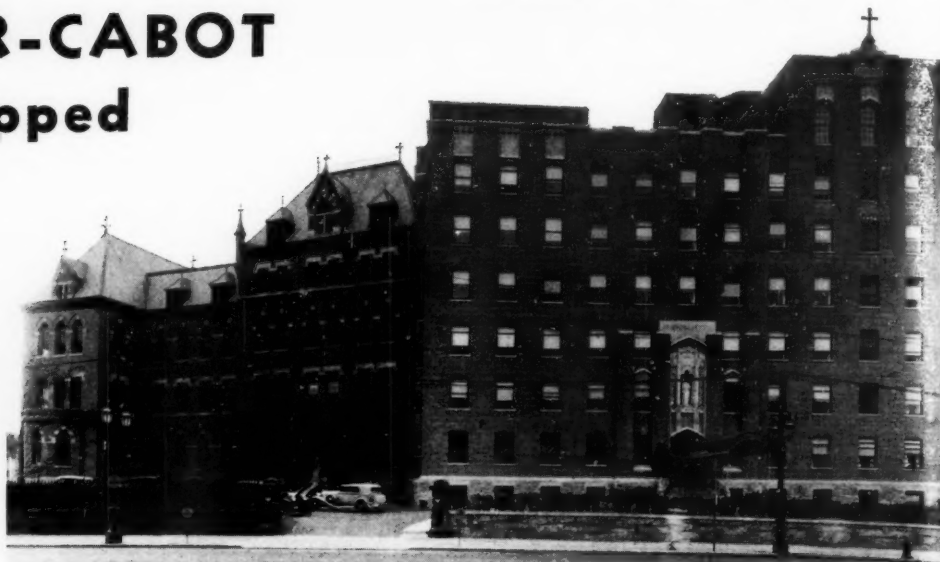
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The St. Joseph's Hospital, Yonkers, N. Y., equipped with Holtzer-Cabot Nurses' Call—Doctors' In & Out—Clinic Call—City Connected Fire Alarm and miscellaneous equipment, is one hospital of many thousands that specify Holtzer-Cabot signaling systems because of their time-proven dependability. Holtzer-Cabot engineers have specialized for over fifty-seven years in the design and development of signaling systems and will gladly assist you with any signaling problem you may have.

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Offices in all principal cities

PIONEERS IN HOSPITAL SIGNALING SYSTEMS

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Smart, swanky, comfortable furniture that creates an indelible impression of confidence in the minds of your visitors

THE "PARK AVENUE" SUITE

The new "Park Avenue" Suite of Chrome-Steel Furniture for the waiting room is the latest, ultra-modern addition to the extensive Wocher line.

Stylish in a dignified manner—comfortable as only Chrome-Steel can be—this new suite will add prestige to your waiting room and put your visitors in a more restful and confident frame of mind.

KEEP STEP WITH MODERN METHODS.... SEND FOR COMPLETE DESCRIPTION

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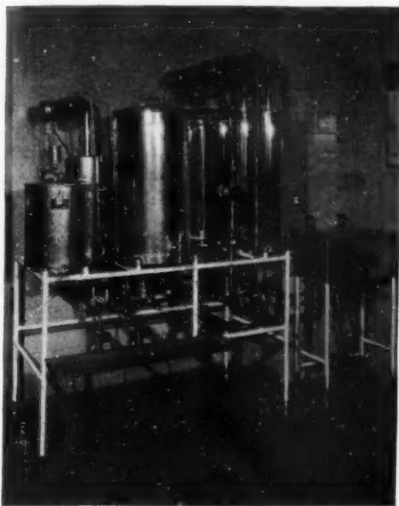
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Cincinnati, Ohio

MOUNT SINAI HOSPITAL

stops post transfusion chills with

fresh BARNSTEAD DISTILLED WATER



● Barnstead Triple Still that furnishes pure distilled water for all intravenous solutions at Mount Sinai Hospital, New York City.

The Mount Sinai Hospital in New York City has reduced post transfusion chills from 12 percent to 1 percent. Reporting the hospital's technique—Drs. Lewisohn and Rosenthal—state: "If instruments and solutions are prepared properly, citrate transfusions can be used with safety in every case . . . The elimination of the foreign protein element and the use of solutions prepared with triple distilled water are indispensable."

Many other leading hospital authorities are equally emphatic in their insistence that all solutions used in intravenous infusions or transfusions be made only with freshly prepared triple distilled water. And today a large num-

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For Barnstead Triple Stills have been developed expressly for delicate hospital work . . . they produce the purest distilled water . . . free from pyrogenic impurities including bacterial toxins. These stills are made entirely of copper and brass—cannot rust—and all parts that come in contact with water are coated with pure block tin. Approved by the American College of Surgeons.

May we send you recommendations and prices?

*From an article in the February 18, 1933 issue of the Journal of the American Medical Association.

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STILL & STERILIZER CO. Inc.
31 LANESVILL TERRACE, FOREST HILLS, BOSTON MASS.

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SPECIALIZED INDUSTRIAL CLEANING MATERIALS & METHODS

Reduces costs on all maintenance cleaning!

By using Oakite materials for *all cleaning*, experienced hospital executives find it easy to maintain rigid standards of cleanliness.

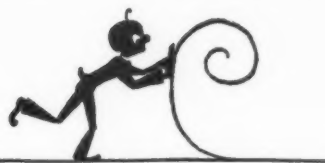
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FOR over 50 years, constant research in our laboratory has kept "Ohio" anesthetic gases the leaders. Many advances in developing smoother anesthesia have come from "Ohio" research and specialization.

Results prove the difference.

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SOLAR WASTE RECEPTACLES are self-closing, sanitary and come in a variety of sizes and finishes.

Send for interesting booklet and attractive prices.

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In hospitals everywhere, Gendron Wheel Chairs are playing an important part in convalescence. Patients find genuine comfort and pleasure in using these superior Wheel Chairs—the finest that modern design and construction can produce.

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The exclusive and Modern Hospital floor machine makes possible proper floor maintenance—easily—quickly and economically.

Greater efficiency because of its increased brush speed and entire concentration of weight directly over brushes.

Amazing simplicity in construction means economy in operation and upkeep cost. Guaranteed permanently noiseless in operation during life of machine.

Modern and scientific principles in design.

Made in three convenient models 14"—18"—22".

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Over 1,000 gallons used in The Drake Hotel of Chicago



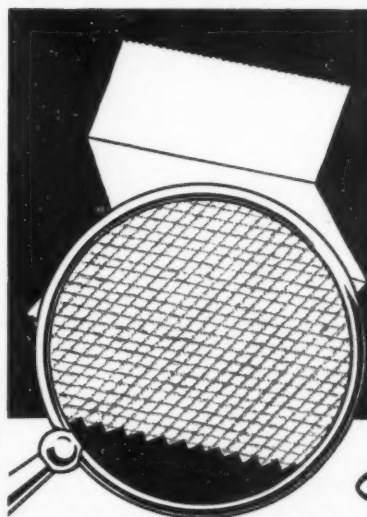
AS in hundreds of other fine hotels, office buildings and institutions,

Barreled Sunlight Flat Wall

Finish gives outstanding dignity and charm to interiors . . . at a surprisingly low cost of application and maintenance.

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Its distinctive
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Looks like cloth, feels like cloth, and is incomparably soft and absorbent . . . entirely different from the usual glaze finish of harsh and brittle types of folded toilet tissue. Evergreen Double Duty towels are also famous for their linen like softness.



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WILTEX
A LATEX PRODUCT
THE WILSON RUBBER CO.
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The Greater Strength of **WILTEX** SURGEONS' GLOVES is Easily Demonstrated

But such a test as that shown below is only part of the story.

The final test is—how many sterilizations will this greater strength add to the life of the glove? In actual use, even after 25 sterilizations, WILTEX has as high a tensile strength as old style brown gloves when new and they will give normally from three to five times as much service before they fail.

So, both for Safety and Economy, the word to use in ordering Surgeons' Gloves is WILTEX.

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Specialists in Rubber Gloves

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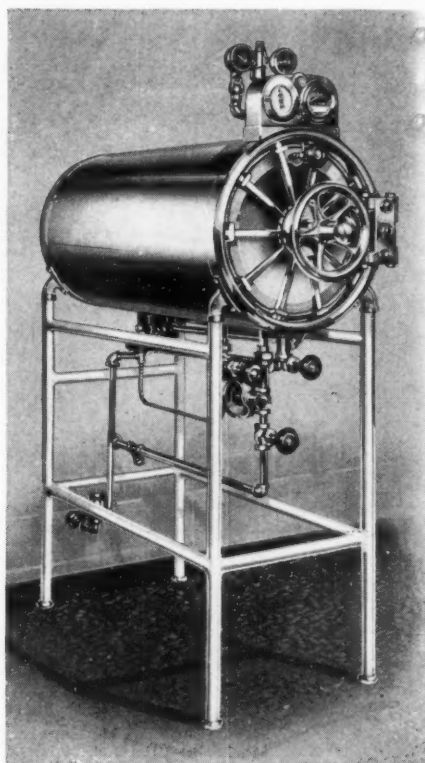
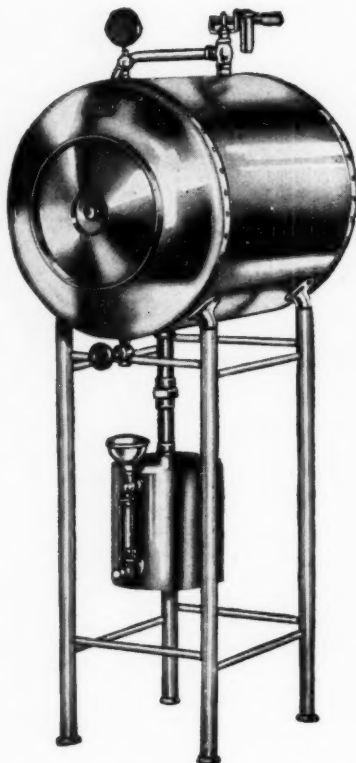
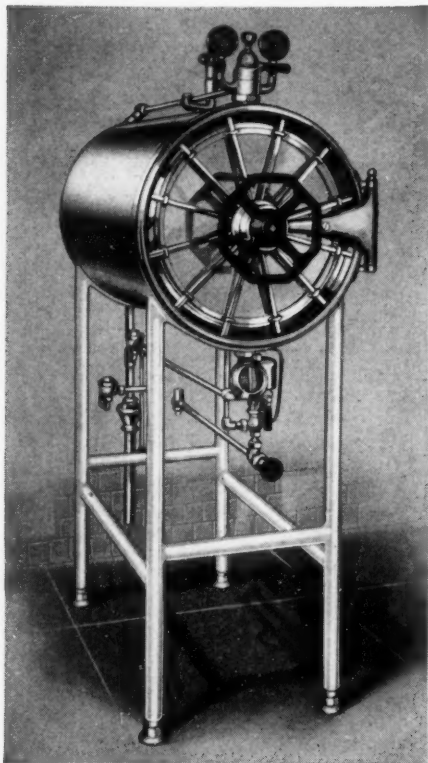


ACTUAL PHOTOGRAPH — WILTEX GLOVE STRETCHED TO SEVEN TIMES ORIGINAL LENGTH



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MONEL METAL!



Leading manufacturers of sterilizers standardize on Monel Metal for sterilizer chambers where rust-proofness and resistance to corrosion are vital...and for steam jackets, where toughness and strength are essential.

**WHERE GREAT STRENGTH,
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Hospital modernization, encouraged and aided by Federal funds, offers an opportunity to replace old type, unsatisfactory equipment with Monel Metal. For information and literature, write,

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York, N. Y.



Monel Metal is a registered trade-mark applied to an alloy containing approximately two-thirds Nickel and one-third copper. Monel Metal is mined, smelted, refined, rolled and marketed solely by International Nickel.



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A NEW AND BETTER ZEOLITE

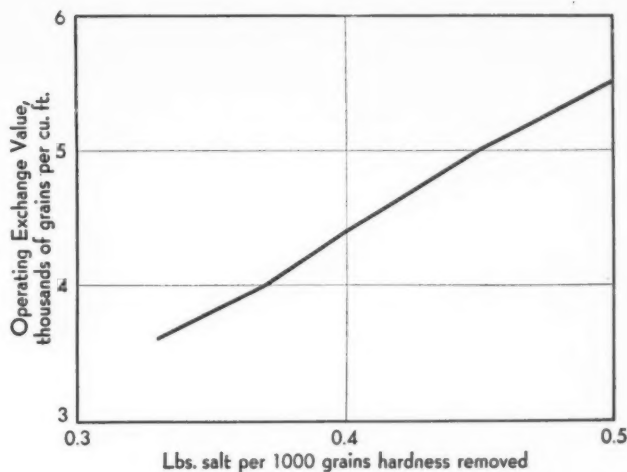
● This is an important announcement to every owner of water treating equipment, and to every plant that needs such equipment. Permutit now offers an improved zeolite for water softeners . . . of higher capacity, of greater ruggedness, of lower salt requirements per 1,000 grains of hardness removed.

Zeo-Dur, Permutit's greensand zeolite, has long been known for its resistance to abrasion. Now, by a series of special treatments, it is made more rugged than ever before, and at the same time its water softening power is increased. We call this new zeolite SUPER-ZEO-DUR. The maximum capacity of SUPER-ZEO-DUR is 75% greater than that of regular greensand zeolite.

LASTS LONGER—Super-Zeo-Dur is tougher and more resistant to abrasion than any other zeolite. Special treatments cleanse and purify it so that the final granule is tougher than ever before. At the same time, these treatments greatly increase its capacity.

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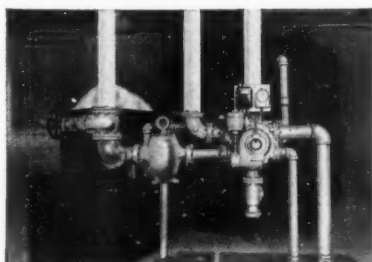
HAS A RESERVE CAPACITY—This new zeolite has a *flexible* capacity. If you need extra water softened, just use proportionately more brine. This flexibility creates a reserve capacity for softening water . . . to be used for emergencies or for increased



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With this new zeolite and fully automatic control, the new Permutit zeolite water softeners are the last word in fool-proof, low cost operation.

We are always at your service to advise you on your water problems, to produce for you water of the specifications which you desire. Find out just how much money a refill of Super-Zeo-Dur in your present equipment will save you! No obligation . . . just write The Permutit Company, 330 West 42nd Street, New York, N. Y.



Permutit Automatic Zeolite Water Softener. Lowers the cost of producing soft water. No over-running. No under-regeneration. Automatic controls can be applied to existing equipment. Write for "No Scale No Sludge, No Mud."

Permutit

Water Treating Equipment



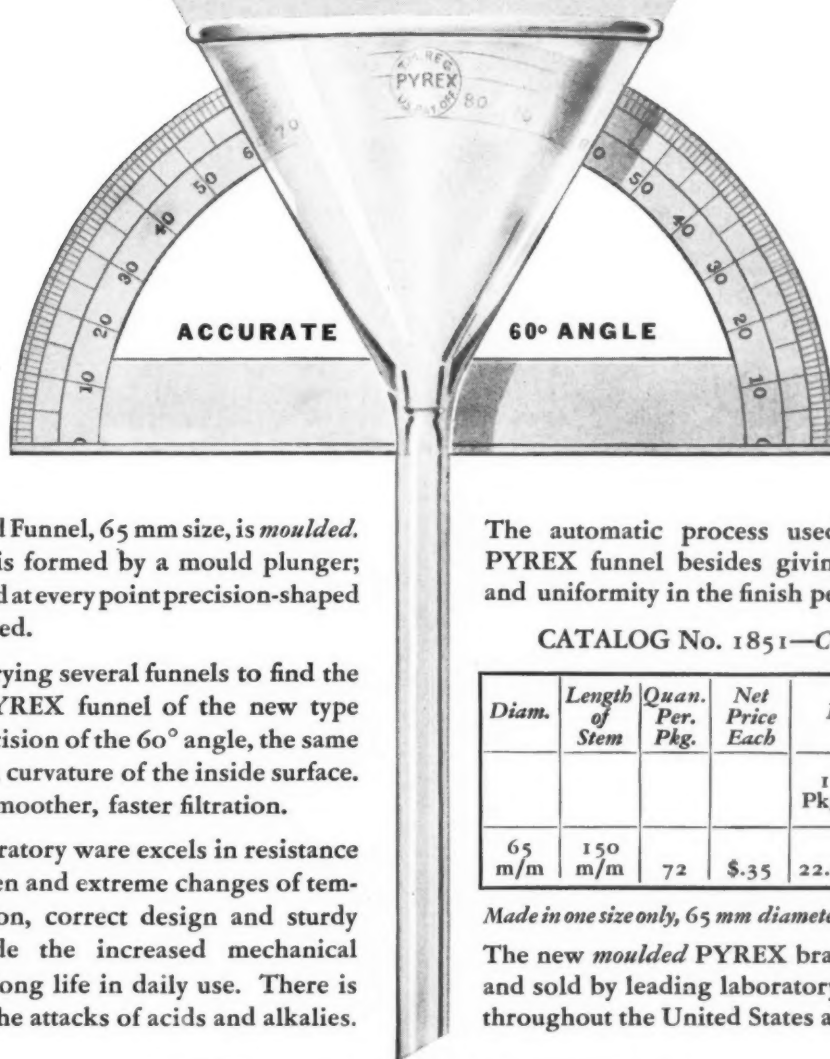
A HOSPITAL in the Middle West increased its patient capacity 25%. Its laundry department soon began to falter. The engineers of The American Laundry Machinery Company were consulted. They carefully checked the washing, extracting and ironing capacity. Then they recommended a thorough modernization, with the addition of a number of larger-production machines. Layouts were submitted—the improvements were made. The investment began to pay dividends at once. Now, in 35% less time per week, that "new" laundry handles 25% more work. Linens have a better finish and work is done with less supplies—operating costs are lower than ever before. For years, "American" engineers have enjoyed the confidence of hospital executives. They have helped to plan new laundry departments, as well as rearrange old ones. In mammoth medical centers, in small clinics and dispensaries. May we again remind you that their services are at your disposal, now or any time, without obligating you in any way. **THE AMERICAN LAUNDRY MACHINERY COMPANY • CINCINNATI, OHIO**



A NEW PYREX^{BRAND} FUNNEL

OF IMPROVED DESIGN

At a Low Price



This PYREX brand Funnel, 65 mm size, is *moulded*. The inside surface is formed by a mould plunger; smooth, uniform, and at every point precision-shaped and accurately tapered.

No need, now, for trying several funnels to find the best one. Every PYREX funnel of the new type shows the same precision of the 60° angle, the same smooth and uniform curvature of the inside surface. Every one assures smoother, faster filtration.

PYREX brand Laboratory ware excels in resistance to heat, and to sudden and extreme changes of temperature. In addition, correct design and sturdy construction provide the increased mechanical strength that gives long life in daily use. There is ample resistance to the attacks of acids and alkalis.

The automatic process used in moulding this PYREX funnel besides giving superior accuracy and uniformity in the finish permits a low price:

CATALOG No. 1851—Code Word BIRIC

Diam.	Length of Stem	Quan. Per. Pkg.	Net Price Each	Net Price Per Package			
				1 Pkg.	25 Pkgs.	50 Pkgs.	100 Pkgs.
65 m/m	150 m/m	72	\$.35	22.68	21.55	20.41	19.28

Made in one size only, 65 mm diameter by 150 mm stem length.

The new *moulded* PYREX brand Funnel is stocked and sold by leading laboratory ware supply houses throughout the United States and Canada.

"PYREX" is a trade-mark and indicates manufacture by

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When you plan FOR THE XRAY DEPARTMENT

WHETHER the project pertains to the modernization of an existing x-ray department, or the formulation of plans for this department in an institution yet to be constructed, there is available technical assistance which can be utilized to real advantage by the architect and the building committee and members of the staff who will sit in conference on this particular phase of the hospital's facilities.

Our *Engineering Service Department* stands ready to advise with you on every detail that enters into the installation of hospital x-ray equipment. The wide experience of this group of specialists in collaborating with many of the largest institutions in the country, can be employed to a very definite advantage in working up plans which you may have under consideration. It may mean the difference between an efficiently operating x-ray department, and one which is handicapped daily because of an impractical arrangement and lack of vision.

Thousands of hospital institutions throughout the world can attest to the valuable service of our engineering staff in the planning of this phase of hospital building and equipping. Here-with is a partial list of hospitals in the United States that have more recently availed themselves of this G-E service.

Inquiry among these institutions and architects will provide you with the preferred first hand information as to our ability and reliability. Then let us place our extensive facilities at your disposal, in view of submitting to your building committee and architects tangible evidence of a thorough and expert advisory service.



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Cedars of Lebanon Hospital, Los Angeles, Cal.
St. Francis Hospital, San Francisco, Cal.
Sutter Hospital, Sacramento, Cal.
State Narcotic Hospital, Spadra, Cal.
Denver General Hospital, Denver, Col.
Mercy Hospital, Denver, Col.
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Bridgeport Hospital, Bridgeport, Conn.
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City Hospital, Columbus, Ga.
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Mercy Hospital, Chicago, Ill.
Augustana Hospital, Chicago, Ill.
Cook County Hospital, Chicago, Ill.
Mason County T. B. Sanatorium, Decatur, Ill.
St. Joseph's Hospital, Keokuk, Ia.
Halstead Hospital, Halstead, Kans.
Bethany Methodist Hospital, Kansas City, Kans.
U. S. Penitentiary Hospital, Leavenworth, Kans.
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Johns Hopkins Hospital, Baltimore, Md.
Massachusetts General Hospital, Boston, Mass.
Boston City Hospital, Boston, Mass.
Cambridge City Hospital, Cambridge, Mass.
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Worcester City Hospital, Worcester, Mass.
Pondville State Hospital, Wrentham, Mass.
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Pontiac State Hospital, Pontiac, Mich.
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Barre City Hospital, Barre, Vt.
Mary Fletcher Hospital, Burlington, Vt.
Sheridan County Memorial Hospital, Sheridan Wyo.
Norfolk Protestant Hospital, Norfolk, Va.
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ANESTHETIST—Graduate of eastern school; graduate training in obstetrics, Sloane Hospital; postgraduate course in anesthesia, University of Pennsylvania; two years, obstetrical supervisor, large eastern hospital; five years' experience in administering all anesthetics; willing to combine her duties. 132.

ANESTHETIST—Graduate of one of leading schools in middlewest; course in anesthesia, Mayo Clinic; thoroughly experienced in administering all anesthetics. 133.

DIETITIAN—B.S. degree, Columbia; six years, teacher in home economics; seven years, administrative dietitian and teacher of special diets, group of teaching hospitals. 134.

POSITIONS WANTED—Continued

MEDICAL BUREAU
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Chicago, Illinois

DIETITIAN—B.S. degree, state university; course in hospital dietetics, Presbyterian Hospital, Chicago; two years, assistant dietitian, large eastern hospital where she has had complete charge of special diet kitchen, nutrition clinic and taught diet therapy to student nurses. 135.

DIRECTOR OF NURSES—B.S. and graduate nurse degrees, University of Cincinnati; five years, educational director in training school having more than 200 students; four years, director of nurses, 175-bed hospital. 136.

DIRECTOR OF NURSES—Will consider, too, a position as educational director; A.B., M.A. degrees; graduate, university school of nursing; extensive postgraduate training in pediatrics; seven years, assistant dean, university group; widely known as leader in her field. 137.

RECORD LIBRARIAN—B.S. degree; six years, record librarian on staff of hospital averaging 200 patients. 138.

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SUPERVISOR—Graduate of one of leading schools in middlewest; past four years, supervisor, men's surgical floor, university hospital; three years' university training; recommended as capable supervisor, possessing marked executive and teaching ability. 143.

SUPERVISOR—Graduate of one of leading hospitals in middlewest; two years, assistant superintendent, 80-bed hospital; past four years, night superintendent, 150-bed institution; age 40. 144.

SUPERVISOR—B.S. and graduate nurse degrees, state university; four years, supervising and instructing obstetrics, 150-bed hospital; part time floor duty obstetrics and gynecology, university hospital while attending university past year. 145.

SUPERVISOR—Graduate of midwestern training school; normal school training; taught in public school several years before entering training; postgraduate training in surgery at Mayo Clinic; nine years' experience as operating room supervisor. 146.

SUPERVISOR—Postgraduate training in surgery and operating room technique, Polyclinic Hospital, New York; five years, assistant operating room supervisor, 350-bed hospital. 147.

SUPERVISOR—Graduate of New England Hospital; postgraduate course in supervising; three years, orthopedic supervisor, 600-bed institution. 148.

SUPERVISOR—A.B. and graduate nurse degrees, state university; postgraduate training pediatrics, University of Cincinnati; two years' supervising experience. 149.

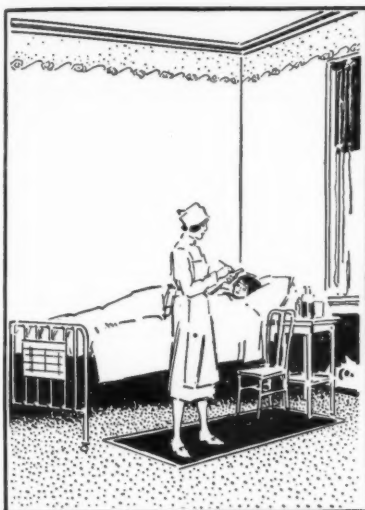
SUPERVISOR—Graduate, university hospital; two years' college training; postgraduate course in psychiatry; three years, supervisor psychiatric ward, 175-bed institution. 150.

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(Continued on page 132)



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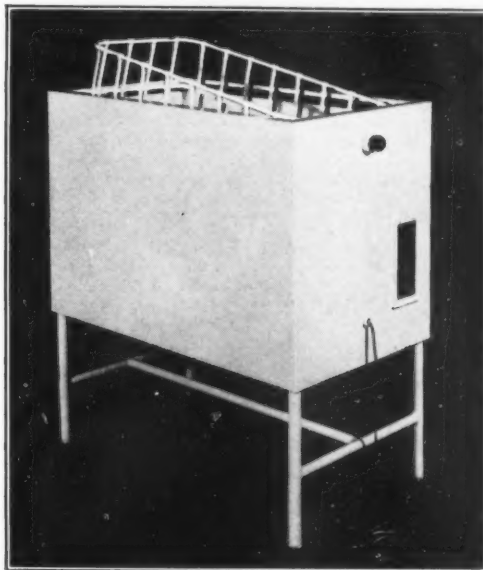
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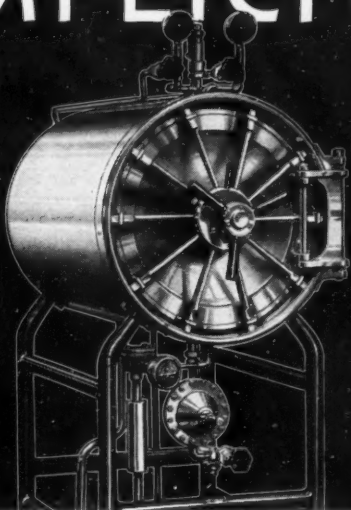
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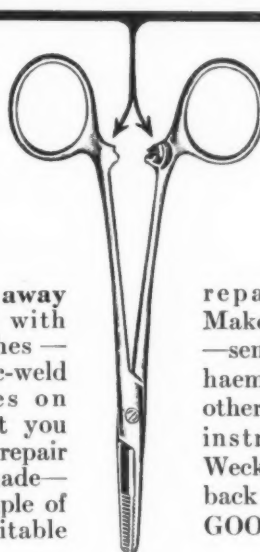


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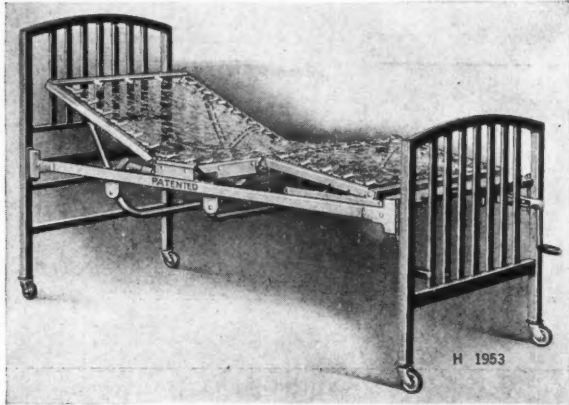
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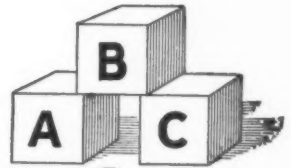
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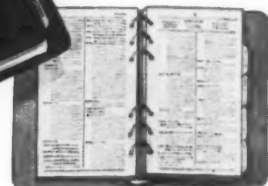
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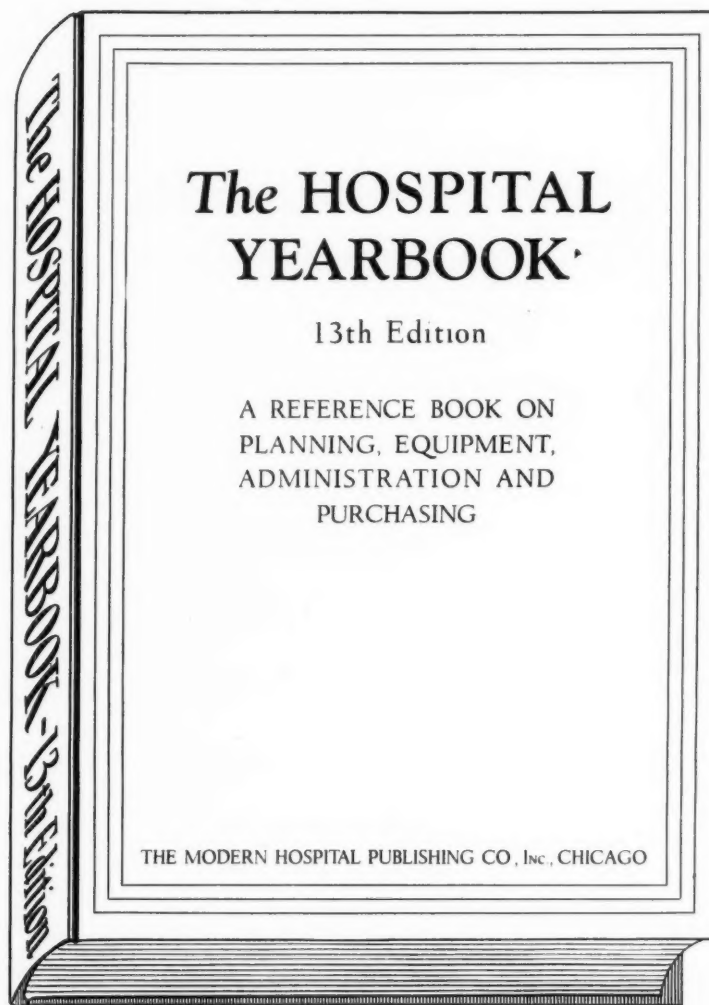
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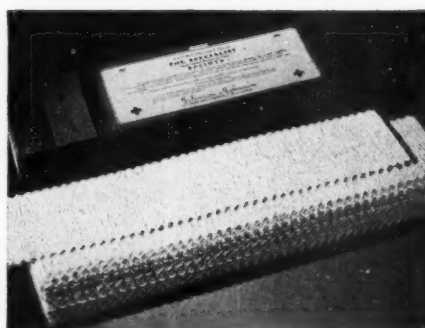
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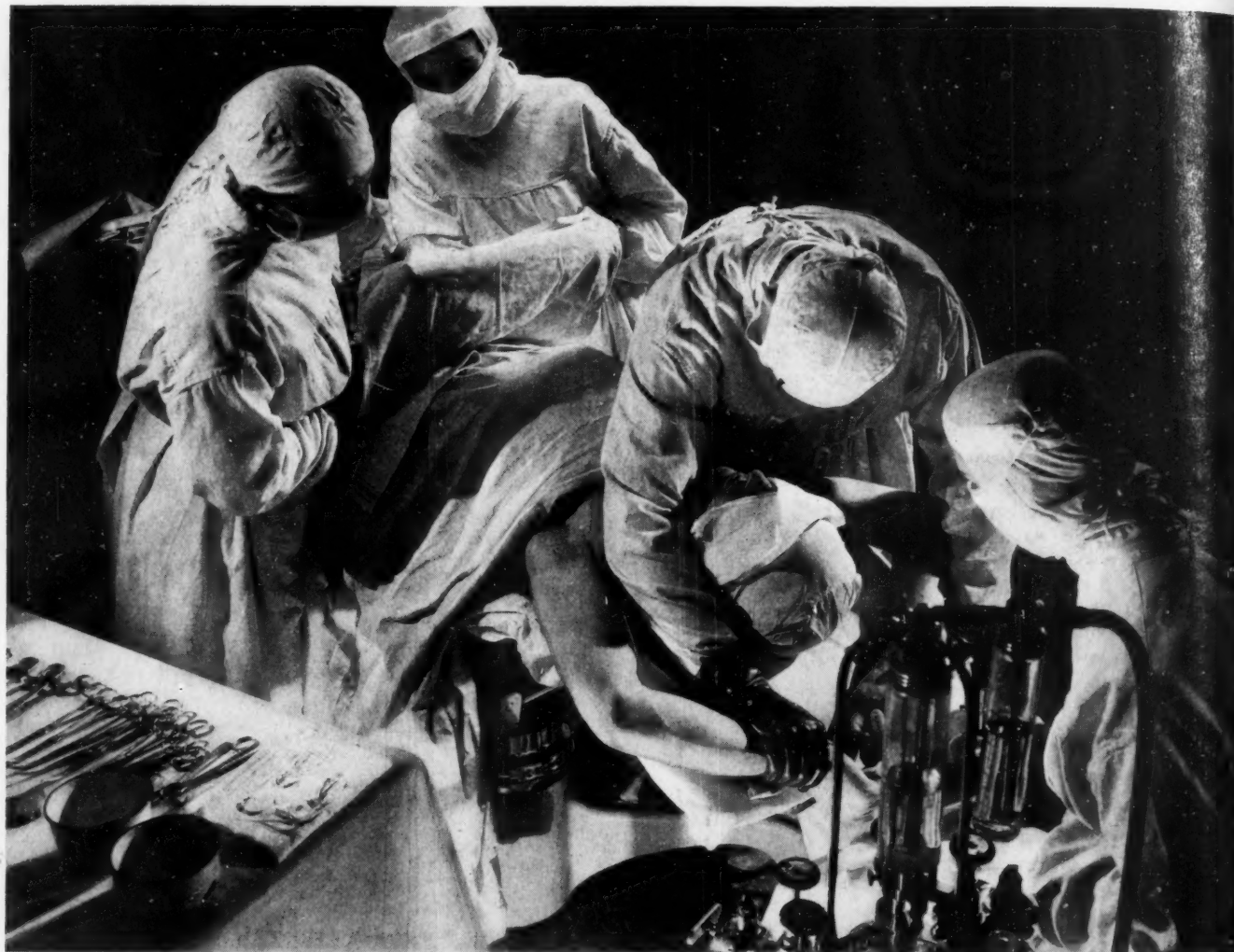
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